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Vol. 16, No. 1
January, 1967

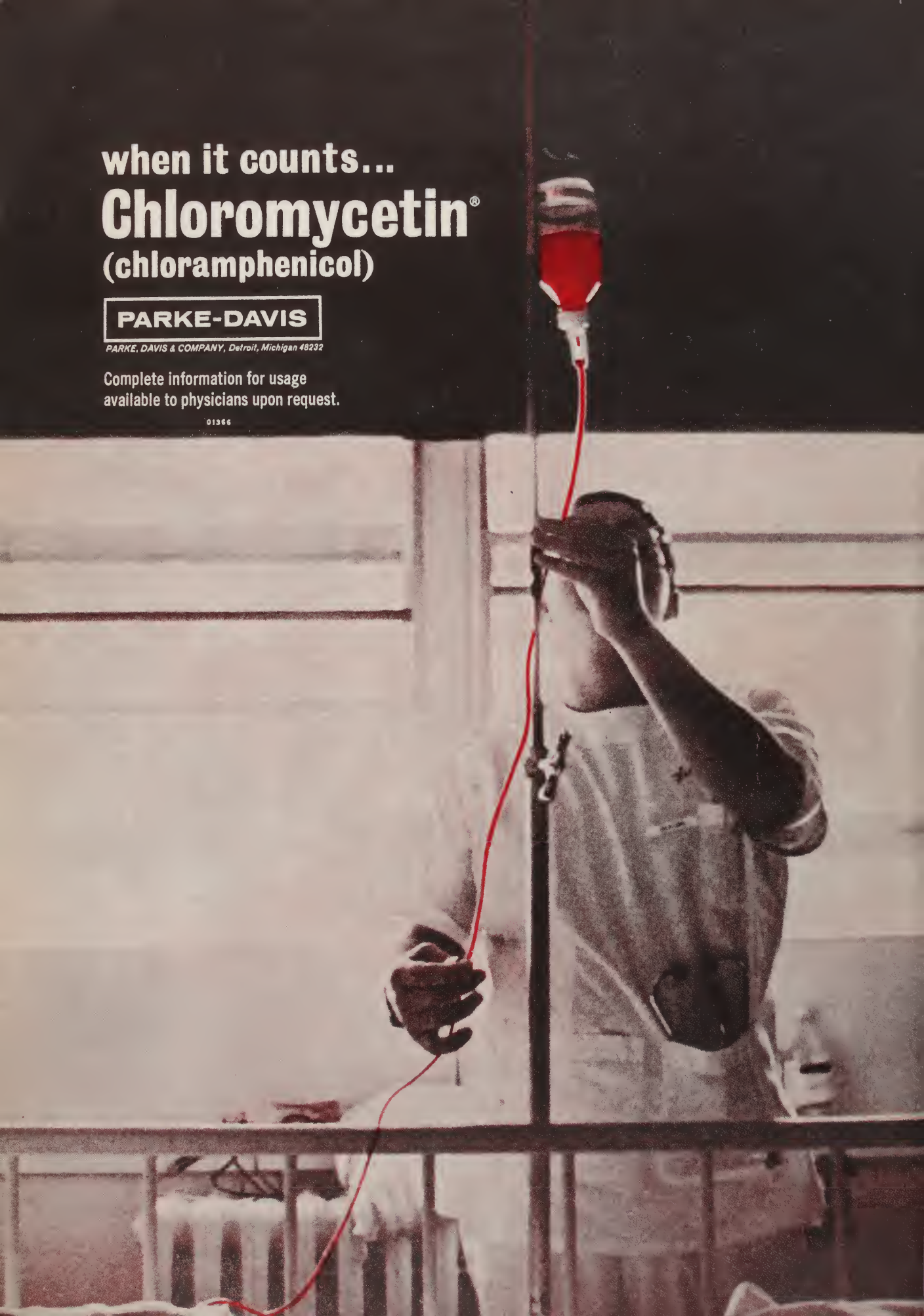
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STATE MEDICAL JOURNAL

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Specify the RPR Card Test as the screening procedure on serum or plasma samples submitted to your State Approved Laboratory.

(1) Portnoy, J.: Brewer, J. and Harris, A.: PUBLIC HEALTH REPORTS, *77:*645-652, August 1962. (2) Joseph, J. M. and Warner, G. S.: A WORKSHOP MANUAL, Md. State Dept. Health, Bureau of Lab., Balto., Md., September 1962. (3) Wollenweber, H. L.: OFF. PATH., *2*, February 5, 1963. (4) Portnoy, J.: MILIT. MED., *128:*414-417, May 1963. (5) Portnoy J.: THE AMER. JOUR. OF CLIN. PATH., *40:*473-479, November 1963. (6) Buck, A. A. and Mayer, H.: THE AMER. JOUR. OF HYG., *80:*85-90, July 1964. (7) Brown, W. J.: Donohue, J. F. and Price, E. V.: PUBLIC HEALTH REPORTS, *79:*496-500, June 1964. (8) Clayton, J. L.: Lindhardt, E. M. and Fraser, R. S.: PUBLIC HEALTH LAB., *22:*206-207, November 1964. (9) Lucatorto, F. M.; Katz, B. D. and Toto, P. D.: THE J.A.D.A., *69:*697-699, December 1964. (10) Portnoy, J.: PUBLIC HEALTH LAB., *23:*43, March 1965. (11) Reed, E. L.: PUBLIC HEALTH LAB., *23:*96-103, May 1965.



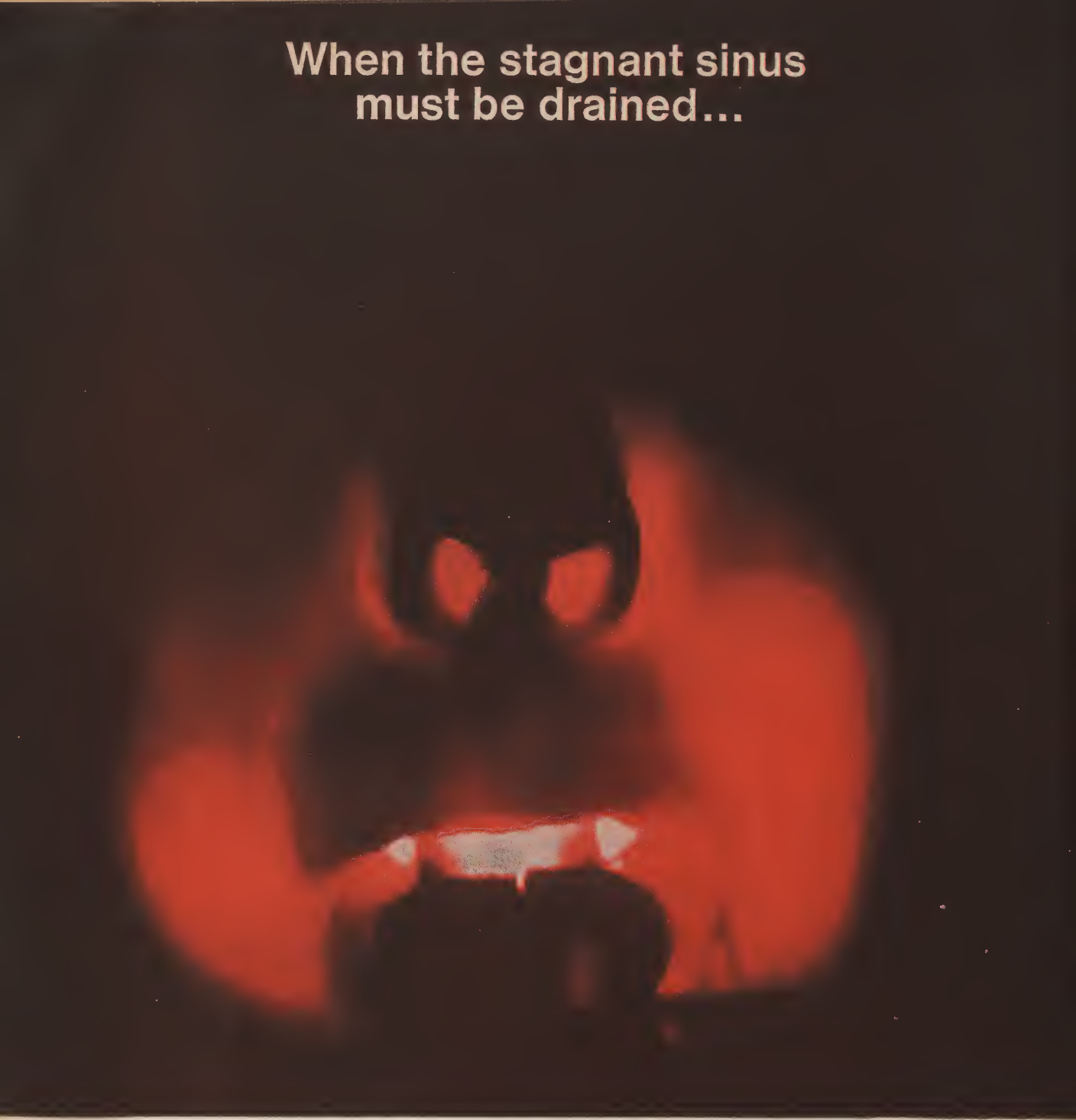
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Maryland
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Vol. 16, No. 1
January, 1967

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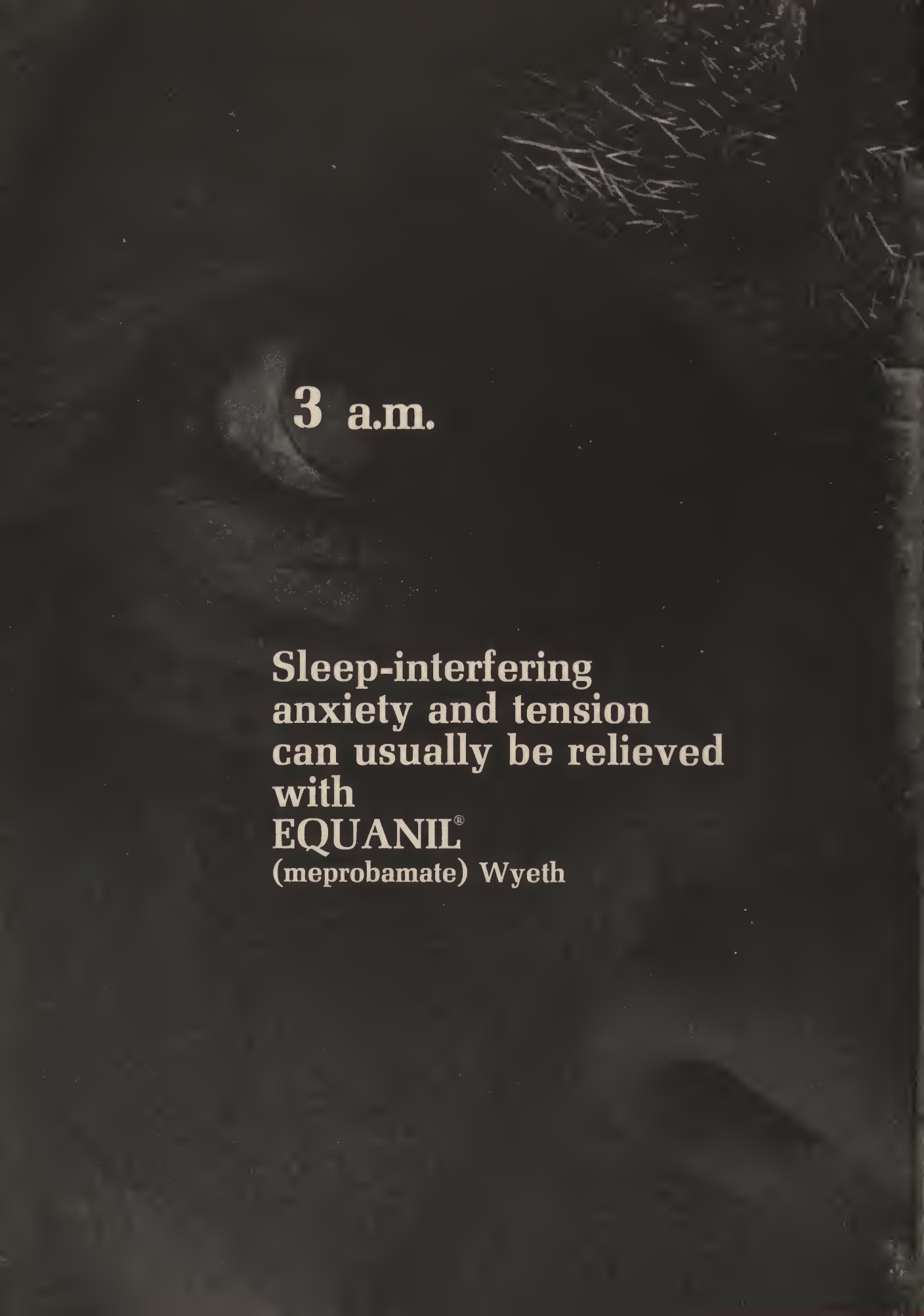
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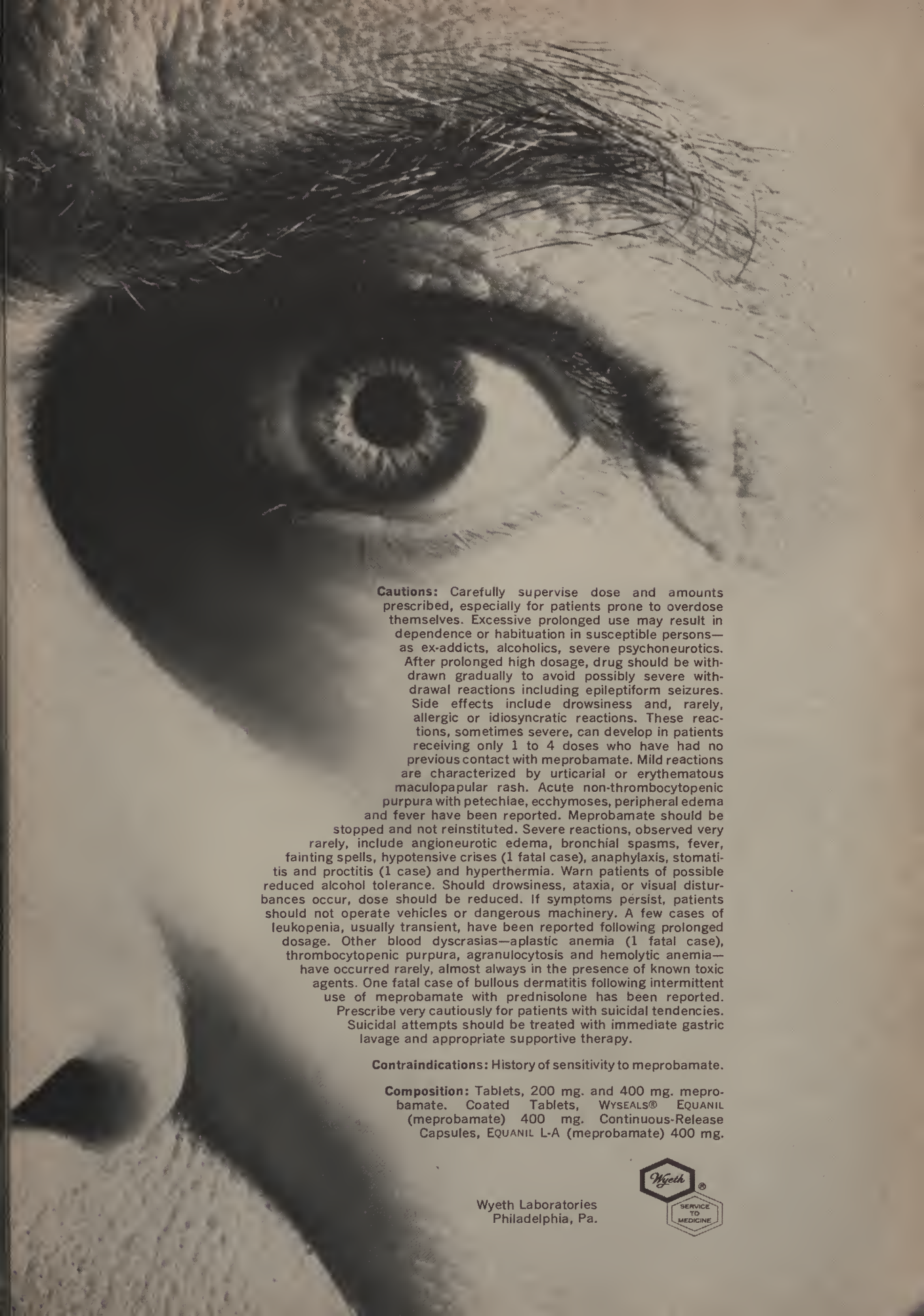
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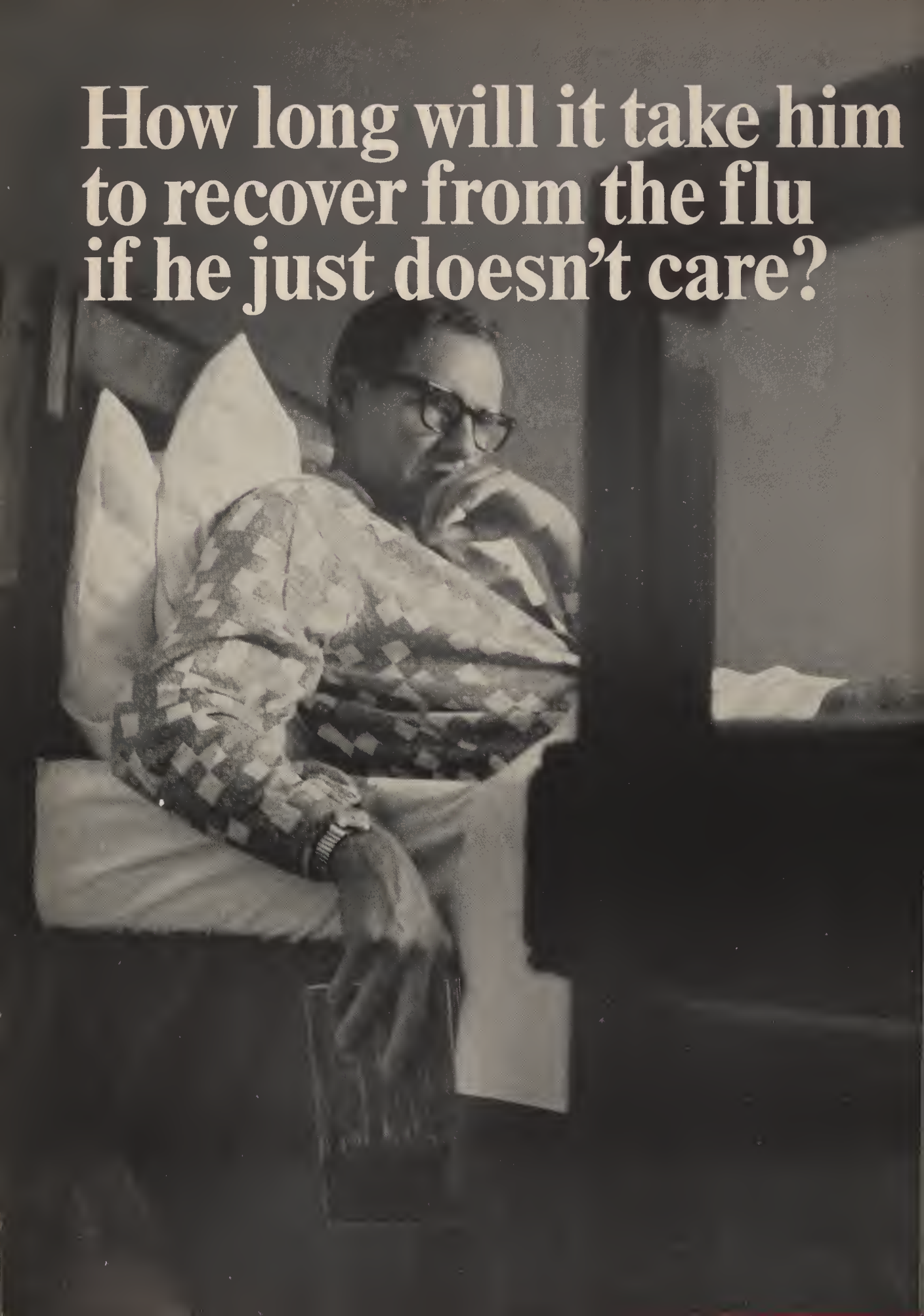
Cautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use may result in dependence or habituation in susceptible persons—as ex-addicts, alcoholics, severe psychoneurotics. After prolonged high dosage, drug should be withdrawn gradually to avoid possibly severe withdrawal reactions including epileptiform seizures. Side effects include drowsiness and, rarely, allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute non-thrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. Meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Warn patients of possible reduced alcohol tolerance. Should drowsiness, ataxia, or visual disturbances occur, dose should be reduced. If symptoms persist, patients should not operate vehicles or dangerous machinery. A few cases of leukopenia, usually transient, have been reported following prolonged dosage. Other blood dyscrasias—aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia—have occurred rarely, almost always in the presence of known toxic agents. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. Prescribe very cautiously for patients with suicidal tendencies. Suicidal attempts should be treated with immediate gastric lavage and appropriate supportive therapy.

Contraindications: History of sensitivity to meprobamate.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

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*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.

Indications: 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

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Side effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

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Doctors take note...

MEDIC

FRIDAY POSTGRADUATE PROGRAMS

(See page 149 for list of locations where MEDIC programs may be heard)

JANUARY 27—1 PM

Differential Diagnosis of Growth Retardation and Sexual Infantilism in Adolescence

Robert M. Blizzard, MD, Associate Professor of Pediatrics, The Johns Hopkins University School of Medicine.

FEBRUARY 3—12:30 PM

Mental Retardation, Pseudo-Retardation and School Failure

Raymond L. Clemmens, MD, Associate Professor of Pediatrics, University of Maryland School of Medicine.

FEBRUARY 10—12:30 PM

Acute Head Injuries

Perry Black, MD, Instructor of Neurosurgery, The Jahns Hopkins University School of Medicine.

FEBRUARY 17—12:30 PM

Clinical Studies of Diabetes

Thaddeus E. Prout, MD, Chief, Department of Medicine, Greater Baltimore Medical Center.

FEBRUARY 24—1:00 PM

Pineal Gland

Richard J. Wurtman, MD, National Institutes of Health, Bethesda.

Appropriate AAGP credit is given for every MEDIC program attended.

MEDICINE 1967

Sunday afternoons at 2:00 PM

WMAR-TV (Channel 2)

January 29

Are You Confused About MEDICARE?

Arranged By
ISRAEL ZELIGMAN, MD

February 5

What Does Medicaid Mean?

Arranged By
ISRAEL ZELIGMAN, MD

February 12

Medical Public Relations

Arranged By
CHARLES E. CARR, JR., MD

February 19

Teen-age Psychiatry

Arranged By
EMMANUEL A. SCHIMUNEK, MD

February 26

Medical Panel

(Questions and Answers)

Arranged By
HARRIS LOVICE, MD

Sponsored by the

Committee on Public Medical Education and Public Relations

BALTIMORE CITY MEDICAL SOCIETY

William Schuman, MD, chairman

[See MEDICAL NEWS, p 29, for details on the first two programs of the series]



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HEART ASSOCIATION OF MARYLAND

January 25

KICK-OFF LUNCHEON

Emerson Hotel, Baltimore

February 26

Heart Sunday

AMERICAN COLLEGE OF CARDIOLOGY

February 15-19

16th Annual Session

Washington Hilton Hotel, Washington, DC

For infarmotion, write: William D. Nelligan, executive director, ACC, 9650 Rackville Pike, Washington, DC, 20014

MARYLAND PSYCHIATRIC SOCIETY

January 26

Annual Dinner

Sheraton-Belvedere Hotel, Baltimore

February 9

Joint meeting with Baltimore Psychoanalytic Society

1211 Cathedral Street, Baltimore

TWELFTH INSTITUTE ON COORDINATED HOME CARE

February 15-17

Presented by Home Care ond Extended Services Department of Montefiore Hospital and Medical Center in cooperation with US Public Health Service. $50.00 registration fee.

Far informotion, write the director of Training Programs in Home Care ot the Center, 111 East 210 St., Bronx, N.Y. 10467.

BALTIMORE CITY MEDICAL SOCIETY

February 3, 8:30 PM

SYMPOSIUM ON SHOCK
Given by the Shock-Trauma Unit of the University of Maryland School of Medicine

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Postgraduate Courses

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Feb. 1 through May 24 $150.00
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Emphasizing the practical application of anatomy and anatomical principles in physical and x-ray diagnosis. Anatomical knowledge is related to the use of needling in performing diagnostic procedures and in treatment. The course is directed toward both the medical man and the surgeon. It is an aid in preparation for the American Board Examination.

GYNECOLOGY

February 9, Fee $15.00

Under the direction of Edmund Middleton, MD
Designed to be of interest to the general practitioner and/or the specialist.

DIABETES

March 2, Fee $15.00

Under the direction of Charles E. Shaw, MD and THOMAS B. CONNOR, MD

Presenting recent advances of great practical interest in this field.

HEMATOLOGY

March 16, Fee $15.00

Under direction of Carroll L. Spurling, MD

A review of current trends and investigative efforts in selected areas of hematology and their implications, both practical and theoretical.

IN-SERVICE PROGRAM

$25.00

The enrollee spends a week in pre-selected department, accompanying members of the department on Rounds, Conferences, Clinics, etc. Time is arranged upon application. This course will not be available during the months of May, June, July.

For information, write: Committee on Postgraduate Education, University of Maryland School of Medicine, 522 W. Lombard St., Baltimore, Md. 21201.

GENETICS IN MEDICAL PRACTICE

January 26-27

A two-day seminar at Howard University College of Medicine, Washington, DC.

No registration fee

Question and answer period

For further information, see Classified Advertising, p. 150

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The following courses are made possible by the generous cooperation of the directors and institutions involved. Tuition fees: Members, $60.00; Nonmembers, $100. Registration forms and requests for information are to be directed to: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104

FEBRUARY 6-10

Biochemical Mechanisms in Internal Medicine

Washington University School of Medicine, St. Louis, Mo; Carl V. Moore, MD, FACP; Sol Sherry, MD, FACP; and William Daughaday, MD, co-directors

FEBRUARY 27-MARCH 3

Arthritis and Related Disorders

New York University Medical Center, New York, NY; Currier McEwen, MD, FACP, and Edward F. Hartung, MD, co-directors.

MARCH 6-10

Recent Advances in Cardiovascular Disease

The Mount Sinai Medical Center, New York, NY; Charles K. Friedberg, MD, FACP, director.

MARCH 13-17

Physiological Aspects of Cardiopulmonary Disease

Yale University—New Haven Medical Centers, New Haven, Conn; Frank D. Gray, MD, FACP director; Donald F. Egan, MD, co-director.

MARCH 20-24

Fundamental Concepts of Gastroenterology

University of Michigan Medical Center, Ann Arbor, Mich; H. M. Pollard, MD, FACP, director.

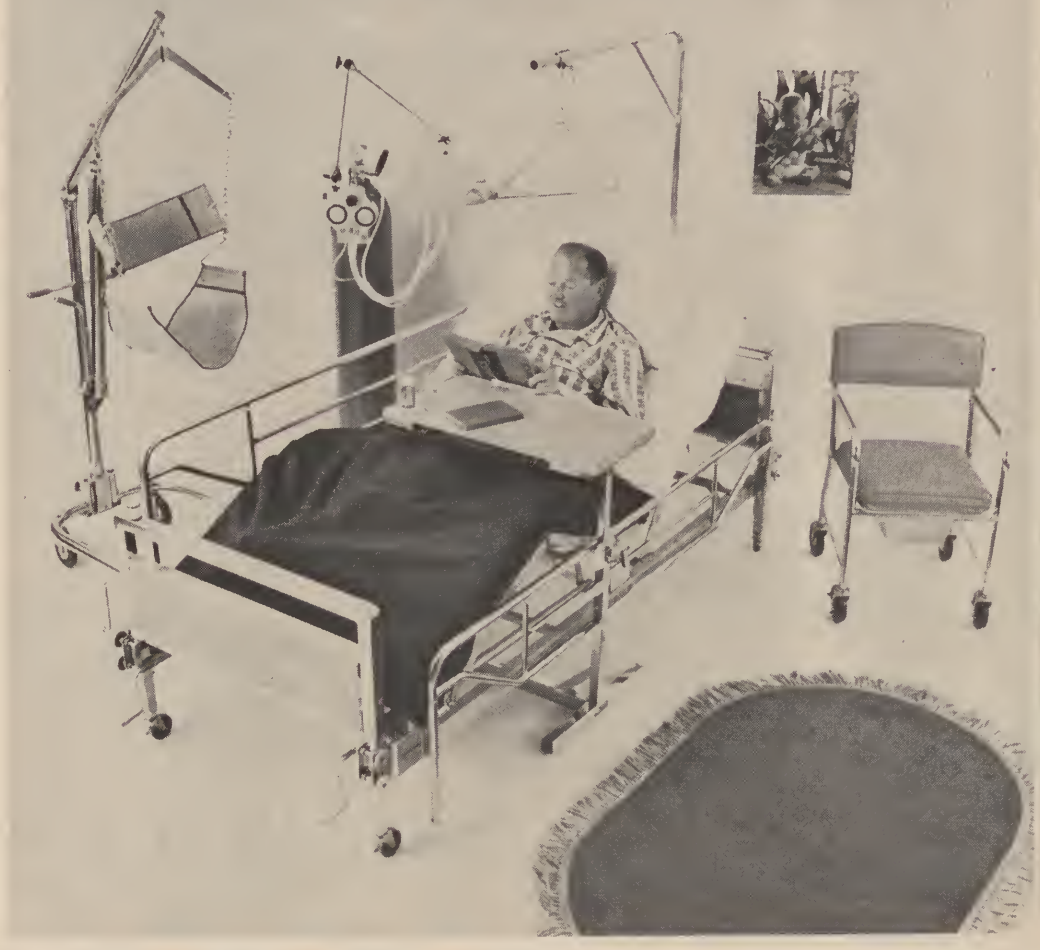
MARCH 27-31

Psychiatry for the Internist

Wayne State University School of Medicine (Lafayette Clinic), Detroit, Mich; Paul Lowinger, MD, director; Victor Bloom, MD, co-director.

(Continued)

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For information, write: Executive Office, The American Academy of Allergy, 756 North Milwaukee Street, Milwaukee, Wis. 53202.

AMERICAN MEDICAL ASSOCIATION COUNCIL ON RURAL HEALTH

March 10-11

20th National Conference

Charlotte, NC

For information, write: Council on Rural Health, AMA, 535 North Dearborn St., Chicago, Ill. 60610.

AMERICAN COLLEGE OF SURGEONS

March 11-13

Sectional Meeting for Doctors and Nurses

Williamsburg, Va

For information, write: Communications Division, American College of Surgeons, 55 East Erie St., Chicago, Ill. 60611.

NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

March 6-9

30th Annual Meeting

Lectures, medical motion pictures, symposia, clinico-pathologic conference, exhibits, entertainment.
30½ accredited hours by AAGP Registration Fee $25.00

Roosevelt Hotel, New Orleans

For information, write: Secretary, New Orleans Graduate Medical Assembly (Sponsor), Room 1528, 1430 Tulane Ave., New Orleans, La. 70112.

NATIONAL MEDICOLEGAL SYMPOSIUM

March 9-11

Jointly sponsored by the American Medical Association and the American Bar Association.
The registration fee of $30 includes a reception and a copy of the proceedings.

Fontainebleau Hotel, Miami Beach

For information, write: Law Division, American Medical Association, 535 North Dearborn St., Chicago, Ill. 60610.

CLINICAL APPLICATIONS OF ADVANCES IN CANCER RESEARCH

March 11

A one-day seminar presented by the Georgetown University Medical Center (sponsored by the District of Columbia Division of the American Cancer Society)

A registration fee of $5.00 includes luncheon and an afternoon reception.

Georgetown University Medical Center

For information, write: Division of Oncologic Surgery, Department of Surgery, Georgetown University Medical School, Washington, D.C. 20007.

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February 24, 25, 26

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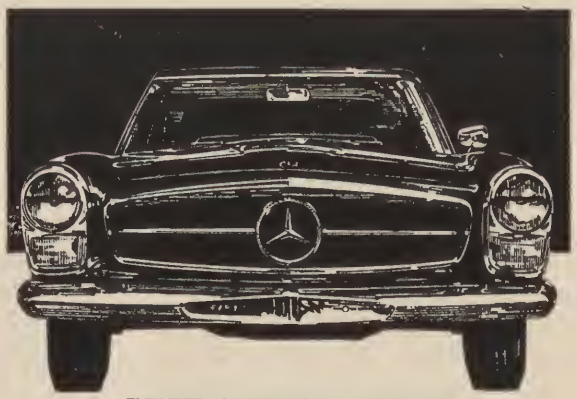
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EXECUTIVE SECRETARY'S NEWSLETTER

January, 1967

DUES BILLS IN MAIL

1967 dues bills have been mailed to all physicians throughout the State. If you have not received your bill, due to mail difficulties, let us know.

All physicians are reminded that Legal Defense is not available unless dues are paid before January 31, 1967.

ANNUAL MEETING RESOLUTIONS

Resolutions for consideration at the Faculty's Annual Meeting should be received in the Faculty office by:

WEDNESDAY, FEBRUARY 22, 1967

The Reference Committee will meet to consider the resolutions received on Wednesday, March 29, 1967, at 8:00 p.m., in the Faculty Building, 1211 Cathedral Street, Baltimore.

SUPERFERTILITY STUDY

The Clinical Center, National Institutes of Health, is conducting a Superfertility Study. Patients who have delivered spontaneously more than one set of twins, triplets, or other multiple births, are needed for the study.

Interested physicians should contact the Faculty office.

FACULTY PRESIDENT HONORED

The Faculty President, J. Morris Reese, M.D., has been honored by the University of Maryland for his 42 years as a teacher in the School of Medicine. He was named Professor Emeritus of Obstetrics and Gynecology, effective December 1, 1966.

NEWS NOTES

Robert C. Kimberly, M.D., Baltimore, has been named President-elect of the Society of Medical Consultants of the Armed Forces.

E. H. Silverstein, M.D., has announced the opening of his offices for the practice of Dermatology at the Mt. Vernon Medical Building and the Milford Medical Building.

New Active members of the American Society of Anesthesiology include: Drs. Manuel J. Balseiro, Silver Spring; Gus E. Cezeauz, Jr., Wheaton; Alison B. Wilhelm, Cheverly; Anthony R. Boccuti, Baltimore; and Pedro M. Pabon, Camp Springs.

New Junior Members are: Drs. Helmut F. Cascorbi, Ellen A. Millan, Mohammed A. Shakoor, Jose C. Arroyo, and Nelson J. Realo, all of Baltimore.

Maher W. Ishak, M.D., Havre de Grace, is a new Diplomate of the American Board of Surgery.

H. L. Wollenweber, M.D. has announced the association of James B. T. Foster, M.D., in the practice of Pathology.

RULES AND REGULATIONS WITH WHICH PHYSICIANS MUST COMPLY

A complete compendium of Rules and Regulations with which Physicians in Maryland must comply is now available to Faculty members. Initial copies have been included with the first issue of The Assemblyman. Additional copies are available while the supply lasts.

For complete details in connection with the "capsule" opinions rendered in this booklet, the appropriate law or regulation should be consulted.

If you did not receive your copy, won't you let the Faculty office know?

BILLING ON MEDICAL CARE PATIENTS

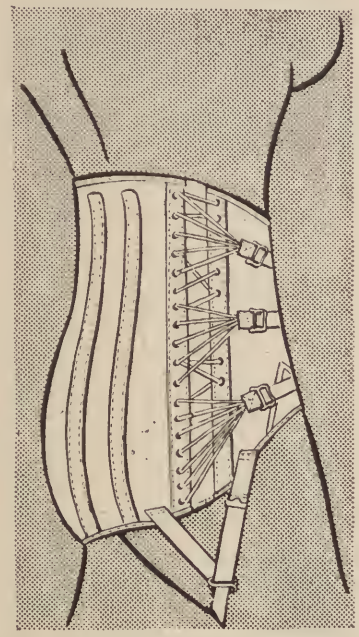
The State Health Department advises that some physicians are not billing for medical care patients at the usual, customary or reasonable fees as recommended by the House of Delegates at the Ocean City meeting this year.

The Commissioner has requested this be brought to the attention of all members so they may comply with the ruling of the House of Delegates. Payments will be made at the current schedule, but this additional information will assist the Health Department in its collection of data for payments when sufficient funds are appropriated for implementation of the usual, customary or reasonable concept.

John Sargeant
Executive Secretary

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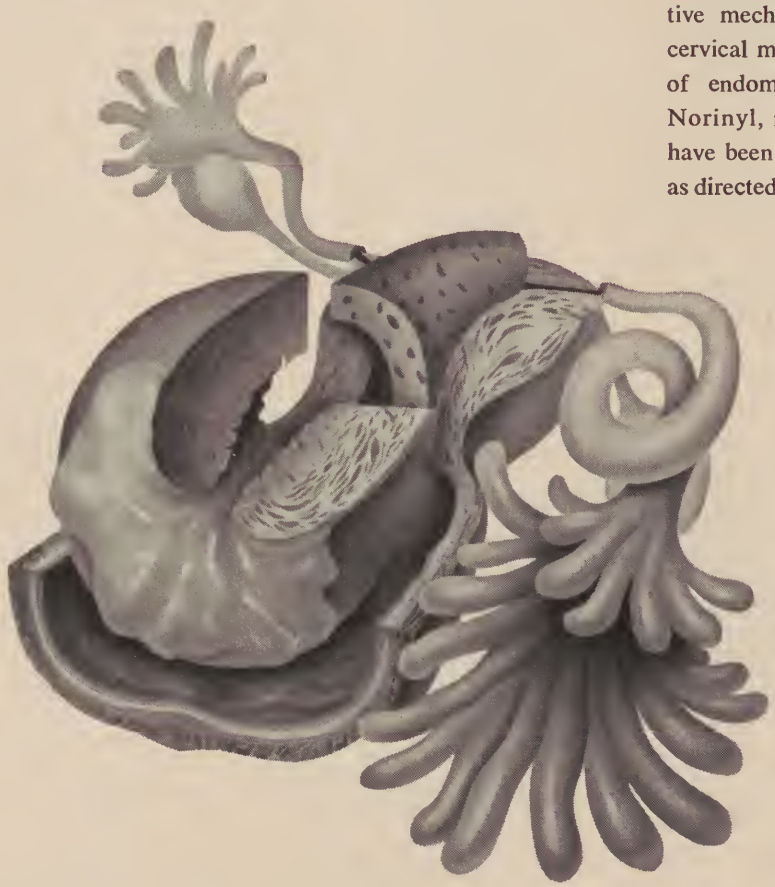
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for multiple contraceptive action that has produced a record of unexcelled effectiveness

inhibition of ovulation by means of 2 time-proved hormonal agents

production of a cervical mucus hostile to sperm motility and vitality

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no unplanned pregnancies

Norinyl provides multiple action for maximum assurance of success. It does not depend on ovulation inhibition alone for contraceptive effectiveness. The mechanism of action of combined hormonal therapy results in ovulation inhibition reinforced by other protective mechanisms, including a hostile cervical mucus[1-13] and an acceleration of endometrial changes.[1-3,7-16] With Norinyl, no unplanned pregnancies have been reported to date when used as directed.

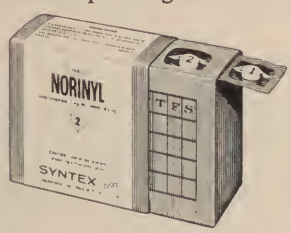
plus important supportive benefits that help her through those critical early months of oral contraception

low incidence of side effects

Low incidence of BTB and spotting, nausea and amenorrhea tends to minimize side effect problems and increases patient cooperation.

no confusion about dosage

An unbreakable "confusionproof" package makes it easy to adhere to prescribed dosage schedule: individually sealed tablets numbered from 1 through 20 *plus* monthly calendar record enables patient to double-check dosage intake by day and corresponding tablet number.



Contraindications: Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to confirm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.

Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism.

Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: 1. Council on Drugs. JAMA 187:664 (Feb. 29) 1964. 2. Bryans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. 3. Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. 4. Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. 5. Hammond, D. O.: Ibid. 6. Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. 7. Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. 8. Kempers, R. D.: GP 29:88 (Jan.) 1964. 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10. Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. 11. Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

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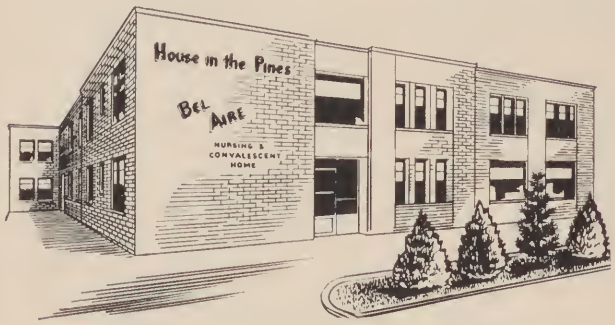
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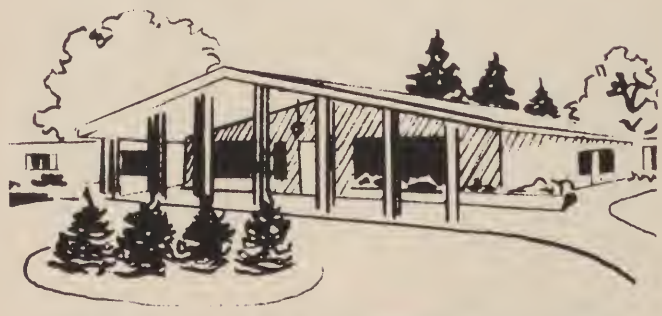


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JOHN SARGEANT EXECUTIVE SECRETARY

Executive Committee, November 17

The Committee authorized recommendation of the following physicians to the State Board of Health and Mental Hygiene as appointees to the Advisory Committee to the Title XIX program for Maryland: George Bauernschub, MD, Baltimore pediatrician; Gilbert D. Barkin, MD, Silver Spring pediatrician; and William A. Rinn, MD; Richard H. Doss, MD; and Anthony F. Stedem, MD, all Baltimore psychiatrists.

Council, November 17

1. On the recommendation of the Public Relations Committee, the Council authorized an expenditure from general funds for 23 subscriptions to *Today's Health* as gifts from the Faculty to Maryland's colleges and universities. The subscriptions will begin in January, 1967, and run for the ten-month school year at an annual cost of $38.64.

2. The Council rejected a proposal to allocate funds for the transportation and lodging of Faculty representatives asked to attend national meetings on the grounds that the current policy of acting upon individual requests for such funds is adequate and accomplishes the same objective. The Committee on Postgraduate Education, Preventive Medicine and Public Health, which made the recommendation, will be advised of the reasons for its rejection; current committee chairmen will be informed of the particulars of the present policy; and future committee chairmen will be so informed at the time of their appointments.

3. Physicians' Defense was ratified for four cases.

4. As a result of queries on the manner of handling Physicians' Defense cases, it was agreed that the Bylaws should be amended to eliminate disparity in interpretations of "based on its merits."

5. Settlement of a case against a physician was reported.

6. Compulsory membership of Faculty members in the American Medical Association was considered in the light of the AMA benefits enjoyed by those who do not share in the cost of rendering them. It was the consensus of the Council that such a change should not be made at this time, but that Faculty members should be encouraged in every way possible to join the AMA.

7. On the recommendation of the Finance Committee, the Council accepted, on behalf of the Faculty, the assignment of a royalty payment from Henry P. Laughlin, MD, and adopted a motion to continue to accept such assignments subject to an agreement approved jointly by the

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due to:

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Council and by Dr. Laughlin.

8. The dates recommended by the Executive Committee for 1967 Council Meetings were approved.

9. Emeritus Membership to the House of Delegates was approved for Philip J. Hirshman, MD, of Hagerstown, and, subject to verification of the fact that he is no longer engaged in active practice, for Samuel L. Tabb, MD, of Wheaton.

10. An amendment to the Employees Pension Plan, as presented by legal counsel and as required by the Internal Revenue Service, was adopted.

11. At the request of Manning W. Alden, MD, who spoke on behalf of the Public Relations Committee, permission was granted to the Committee to explore further the possibility of having the S. S. HOPE dock in Baltimore, with Faculty sponsorship, in late 1967 or late 1968.

12. Acting upon the recommendation of the Policy and Planning Committee relative to the continuing shortage of family physicians, the Council approved the formation of a Committee to arrange for talks to all medical school classes on the various aspects of family practice, with the suggestion that the members of a similar committee of the Maryland Academy of General Practice be asked to serve, in this capacity.

13. An amendment to the Med-Chi Insurance Trust, approved by legal counsel, was unanimously adopted.

14. Because of a lack of adequate information, the Council voted to postpone any discussion of a proposed clinic for chronic respiratory diseases until the January, 1967, meeting.

15. The Executive Secretary was granted authority to approve the enclosure of Component Society material in Faculty mailings, with such enclosures going either to all Faculty members or to only those who are members of the Component Society involved.

16. The Council was informed that the Bylaws do not at present place any limit on the number of absences from Council Meetings permitted any Council member, and that the Bylaws Committee is considering the recommendation that membership be terminated if three consecutive meetings are missed without due cause or reason.

17. A motion to approve an amendment to the Laboratory Services Subcommittee Report was discussed and tabled.

18. The Executive Secretary reported receipt of a final copy of the State Health Department's request to National Institutes of Health for a plannig grant on PL 89-239 (heart disease, cancer, stroke), together with the Department's request for Faculty endorsement. The requests will be referred to the appropriate Faculty committee for study and recommendation to the Council.

19. The Council voted to receive the written report of, and to dismiss with thanks, the Ad Hoc Committee to investigate reputed attempts of certain universities to discourage the entrance of medical students in the field of general practice. J. Roy Guyther, MD, was chairman of the Committee.

20. The Council accepted the Med-Chi Insurance trust as the official organization to investigate a retirement program for Faculty members, with the understanding that the proposal of the MedReFund would be given due consideration.

21. On the recommendation of John M. Dennis, MD, the Council unanimously approved of Faculty participation in the Maryland Council on Health Affairs. This council would (1) be a coordinating agency for health facilities and services of all kinds, institutional as well as non-institutional; (2) serve as a central locus for health affairs; (3) serve as a central planning agency for health and service facilities and, in this capacity, assume the functions of the now-defunct Hospital Commission; and (4) act as a coordinating agency for the development of adequate manpower for the health field. The Council expressed its appreciation to Dr. Dennis, who served as Faculty representative to the group involved in the formation of the MCHA and is now serving on a Bylaws Committee preparing appropriate bylaws for recommendation to the Council.

MARK THESE DATES ON

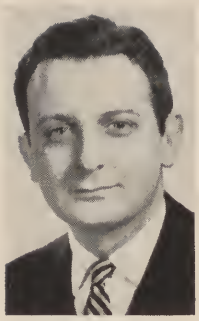
Wednesday, Thursday, Friday

169th ANNUAL

THE MEDICAL AND

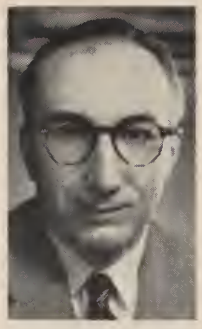
The Alcazar,

SCIENTIFIC PAPERS



Dr. Holland

James F. Holland, MD, chief of medicine A, Roswell Park Memorial Institute, will present a paper entitled *The Principles of Cancer Chemotherapy and their Application.* Dr. Holland attended Princeton University and received his MD degree at Columbia University College of Physicians and Surgeons. After serving as an assistant in medicine at Columbia and assistant attending physician at the Francis Delafield Hospital in New York, he became a staff member at the National Cancer Institute in Bethesda. In 1954 he became associate chief of medicine at the Roswell Park Memorial Institute in Buffalo and in 1956 was appointed to his present position there. Dr. Holland is also associate research professor at the State University of New York in Buffalo. He currently has appointments to various groups and panels in the fields of leukemia, solid tumors and chemotherapy.



Dr. De Bakey

Michael E. De Bakey, MD, who will also be a speaker at the Annual Meeting, is a surgeon whose range of activity encompasses many areas. Associated with Baylor University in Houston, he runs one of the largest cardiovascular centers in the world. One of his headline-making projects is the developmental work on an artificial heart. [See MEDICAL NEWS, p. 31] The current model, which surgeons call a left ventricular bypass pump, temporarily takes over the work of the left ventricle.

In the area of government, Dr. De Bakey serves as a presidential advisor on health programs. He is past chairman of the President's Commission on Heart Disease, Cancer and Stroke, and a present or past member of several advisory councils to the National Institutes of Health.

A native of Louisiana, Dr. De Bakey received his BS, MS and MD degrees from Tulane University. Parts of his residency were served at the University of Strasbourg and the University of Heidelberg.

Since 1948, Dr. De Bakey has been professor of surgery and chairman of the Department of Surgery at Baylor University College of Medicine. He is a consultant in surgery at numerous hospitals in Houston and at the Walter Reed Army Hospital in Washington. Dr. De Bakey is a member of some 52 medical and scientific societies, the author of over 25 publications, and in 1965 was named Doctor of the Year by the *Medical World News.*

[*For news of additional speakers and events, see page 79*]

YOUR NEW CALENDAR

April 19, 20, 21

MEETING OF CHIRURGICAL FACULTY

Baltimore

SCIENTIFIC EXHIBITS

Important educational information will be embodied in the scientific exhibits to be displayed at the Meeting. There is still space available for one or two exhibits, depending on size. Any members interested should contact the Faculty office *promptly*. An Aesculapius Award and a $200 cash prize, donated by Mead Johnson Laboratories, will be presented to the author of the most outstanding scientific exhibit shown. A committee of the Faculty will judge the exhibits.

TECHNICAL EXHIBITS

As of January 1, the following companies have reserved booths for technical exhibits:

Abbott Laboratories
Aloe Medical-Division of Brunswick Corp.
Baltimore Dictating Machine Company
Carnation Company
Ciba Pharmaceutical Company
Community Health Facilities, Inc.
Herbert Cox, Correct Shoes
Dome Laboratories
Encyclopaedia Britannica
Endo Laboratories, Inc.
Federated Business Services, Inc.
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Geigy Pharmaceuticals
Graymar Company
Hummel-Rhode & Co.
Jobst Institute, Inc.
Lederle Laboratories
Eli Lilly and Company
Mallinckrodt Pharmaceuticals
Maryland Blue Cross & Blue Shield Plans
Maryland Pharmaceutical Association
Mead Johnson Laboratories
Med-Chi Insurance Trust
Medco Products Co., Inc.—Alan G. Day
Mercantile-Safe Deposit and Trust Company
Merck Sharp & Dohme
Murray-Baumgartner Surgical Instrument Co., Inc.
Organon Inc.
Pfizer Laboratories
Wm. P. Poythress & Co., Inc.
A. H. Robins Company, Inc.
Roche Laboratories
Sandoz Pharmaceuticals
W. B. Saunders Company
G. D. Searle & Co.
Smith, Miller & Patch, Inc.
Squibb, Inc.
The Stuart Company
Syntex Laboratories, Inc.
U. S. Vitamin & Pharmaceutical Corp.
The Upjohn Company
The William A. Webster Company
Wyeth Laboratories

Smith Kline & French Laboratories and Hynson, Westcott & Dunning, Inc., are making a contribution, although they are unable to have exhibits this year.

Any other company interested in having an exhibit should communicate with the Subcommittee on Exhibits at the Faculty office *at once*. There may still be a few booths unassigned.

BUSINESS SESSIONS

The meetings of the House of Delegates of the Faculty will be held on **Wednesday, April 19,** at the Alcazar, and on **Friday, April 21,** in the Faculty Building.

Night Leg Cramps...Frequent Bedfellow
In Diabetes,[1] Arthritis,[2] and Peripheral Vascular Disorders[2]



now...specific therapy for night leg cramps

QUINAMM™

Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.[3] Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.

QUINAMM Prescribing Information: Composition: Each white, beveled, compressed tablet contains: Quinine Sulfate 4 grains (250 mg.) and Aminophylline 3 grains (200 mg.). **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptams af cinchonism, such as tinnitus, dizziness, and gastraintestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine cantent. **Dosage:** One tablet upan retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets. **Caution:** Federal law prohibits dispensing without prescription.

References: 1. Shumon, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiolagy, 12:102, 1961. 3. Rowls, W., et al.: Med. Times, 87:818, 1959.

WALKER *Laboratories* Division of Richardson-Merrell Inc., Mount Vernon, New York 10551

From Baltimore

An original oil painting of Davidge Hall of the University of Maryland School of Medicine was unveiled December 14 by William S. Stone, MD, dean of the school, following its presentation as a gift to the school by George S. Squibb, vice-president of E. R. Squibb & Sons, Inc. Other participants in the ceremonies, which took place at a luncheon at the Lord Baltimore Hotel, included Charles P. McCormick, chairman of the University of Maryland Board of Regents, and William J. Peeples, MD, commissioner of health of the State of Maryland.

The presentation by the pharmaceutical firm is part of its long-range plan, known as "Collegia Medica," to create a collection of original oil paintings of 86 American medical schools. The firm commissioned John Falter to do the painting of Davidge Hall, which is a replica of the Pantheon in Rome. Erected in 1912, it is the oldest structure in the United States from which the degree of doctor of medicine has been granted.

* * * * *

MEDICINE 1967, the annual series of television half-hours sponsored by the Baltimore City



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University of Maryland School of Medicine
an original oil painting
by John Falter

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Medical Society, will open this season on Sunday, January 29, at 2:00 PM on WMAR-TV (Channel 2). The first program—entitled "Are You Confused About MEDICARE?"—will consist of a panel discussion of some of the major questions asked by the public in connection with the Medicare program. Panelists will be: William G. Speed, MD, assistant professor of medicine, The Johns Hopkins School of Medicine; State Senator-elect Carl Friedler; Mr. Denwood N. Kelly, executive director, Maryland Blue Shield; Mr. P. David Youngdahl, administrator, Frederick Memorial Hospital.

The second program, to be shown February 5, will be called "What Does MEDICAID Mean?" and will feature the following panelists in a discussion of Title XIX: John T. Chissell, MD, member of the Advisory Council of Medical Care of the State of Maryland Department of Health; John B. De Hoff, MD, assistant commissioner of health for local health services, Baltimore City; Wilson L. Grubb, MD, president, Maryland Academy of Pediatrics.

* * * * *

The Maryland Association of Private Practicing Psychiatrists and the Maryland Psychiatric Society have established an annual prize in honor of Wendell Muncie, MD, to be awarded for that piece of original research adjudged to be the most meritorious from those submitted to its committee for consideration. The research is to be done by one or more Maryland psychiatrists out of medical school less than ten years, according to an announcement by Michael J. Bisco, MD, chairman of the prize award committee.

There is to be an award of $100 to the winner, and the paper will be presented at a joint meeting of the Association and the Society on March 9, 1967. Manuscripts must be submitted by February 15, 1967, to Dr. Bisco at 11 East Chase St, Baltimore, Md 21202.

From Washington

The National Institutes of Health is concentrating its efforts in the artificial heart field on support of programs for development of auxiliary heart-pumping devices instead of a complete artificial heart.

The programs include those led by Michael E. De Bakey, MD, of the Baylor University College of Medicine, Houston, and Adrian Kantrowitz, MD, chief of surgical services at Maimonides Hospital, Brooklyn. Other teams working on developing complete artificial hearts will continue their research, but the government will not emphasize their approach.

The decision to forego for the present a major program to build a complete artificial heart was made by James A. Shannon, MD, NIH director, after he determined that not enough fundamental information exists on just how the heart operates to make such a project feasible.

Dr. Kantrowitz described the problems involved in designing artificial heart devices in a speech at a meeting of the American Society of Mechanical Engineers in New York.

"The heart is not a simple pumping device. It receives thousands of signals from other parts of the body," he said.

"For example, when a good-looking blonde walks down the street, your heart speeds up. To make mechanical hearts respond to a blonde will not be so easy. It's better to leave the heart in place to respond to all these signals and make a mechanical pump as an auxiliary device to do most of the work."

Dr. De Bakey is working toward development of a device that would allow the heart to rest long enough for it to recover its strength and resume its role in the body without assistance. Dr. Kantrowitz is working toward development of an implantable auxiliary device that would permanently aid those whose hearts cannot function adequately alone. Both these approaches and others similar to them are of the type the institute wants to support.

"We want to develop both a family of highly efficient short-term devices to tide people over acute heart attacks, and also completely implantable heart-assist devices," an NIH spokesman said; "then, after this type of development is worked out, and devices have been proven in

---

A monthly summary of Washington news prepared in the Washington, DC, office of the American Medical Association.

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clinical trials with a high degree of reliability, and it looks as if total heart replacement is feasible, we will push toward that goal."

Dr. Kantrowitz praised the partnership between physicians and engineers in the artificial heart field, but said efforts must be made to ensure that leadership in research remains with the medical profession and is not given to engineers who do not fully understand the medical problems involved.

* * * * *

Obesity has become a major health problem in the United States and a special health hazard for three obesity-prone groups, according to the Public Health Service.

Quoting a new PHS source book for health professionals, *Obesity and Health,* the Service reports that the prevalence of obesity in this country is a source of growing medical concern because "fat people are more likely to develop certain diseases and to die at an earlier age than people of normal weight."

Prime candidates for the development of obesity, according to the PHS, are:

1. Children whose relatives are obese: In one study, 73% of 1,000 obese patients had at least one obese parent.
2. Heavily built persons who also have corpulent tendencies: Obese individuals usually have a heavier physique than their non-obese counterparts. Large-boned and thickly muscled persons who fit this description, particularly adolescents, should be watched closely.
3. Persons who are becoming less active, more sedentary: Food intake does not decrease proportionately with a decrease in energy expenditure. As activity decreases, for whatever reason, the risk of developing obesity increases.

The Service said that while a substantial amount of obesity exists at every age in both sexes, obesity in children and adolescents is a particulary discouraging omen for the future.

"Obese children and adolescents are a major reservoir for obesity in adult life," the source book said. "They are more likely to remain obese as adults and to have more difficulty in losing fat

and maintaining fat loss than people who become obese as adults."

* * * * *

As a result of a joint government-industry effort to reduce accidental overdose, no bottle of children's aspirin sold after July 1, 1967, will contain more than 36 tablets. This restriction was one of several steps announced jointly by the Food and Drug Administration and 32 drug firms after a conference aimed at curbing childhood deaths and illnesses.

* * * * *

Also by July 1, aspirin for children will be limited in potency to 1¼ grains per tablet, and every bottle will contain this cautionary label: "Precaution: No cap is 100% childproof. In case of accidental overdose, notify physician immediately."

* * * * *

William H. Stewart, MD, surgeon general of the Public Health Service, says the nation's hospitals need 20% more professional and technical workers—primarily nurses—to provide the best patient care.

Stewart's statement accompanied the report of a joint US Public Health Service-American Hospital Association survey which showed that more than 80,000 additional nurses and 40,000 practical nurses are needed, plus 50,000 aides in general hospitals, 30,000 in psychiatric institutions, 9,000 medical technologists, 7,000 social workers and 4,000 physical therapists, X-ray technologists and surgical technicians.

* * * * *

John W. Gardner, Secretary of Health, Education and Welfare, has appointed a six-member Task Force on Environmental Health and Related Problems and instructed it to "think at least 50 years ahead."

Chairman of the Task Force is Ron M. Linton, who was, until last September, staff director of the Senate Committee on Public Works and is now associated with Urban America, Inc.

The Task Force will be concerned, Mr. Linton said, not only with such obvious threats to health as air and water pollution but with "crowding, noise, lack of open space, lack of mobility, dirt." The Task Force will hold hearings in a number of cities, and is scheduled to report to Secretary Gardner by June 1, 1967.

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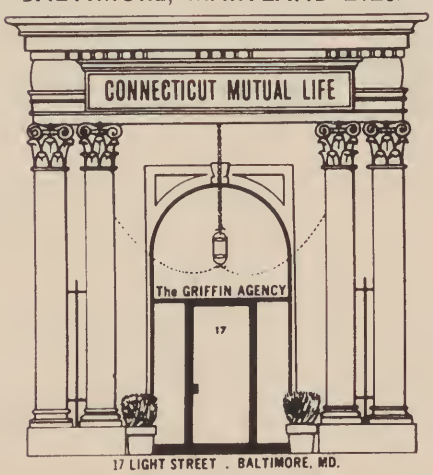




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Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.

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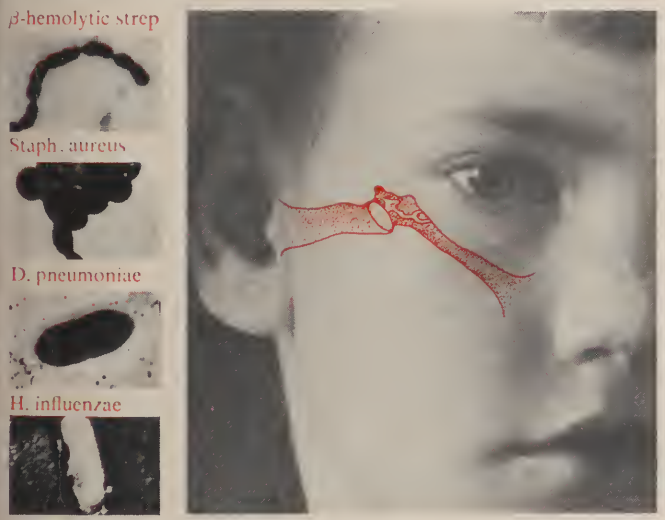

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In addition to this effectiveness against beta-hemolytic streptococci,[1-9] bacteriologic conversion rates have averaged 69% for *D. pneumoniae* (103 of 150 patients),[3,6,7] 78% for *H. influenzae* (42 of 54 patients),[3,4,7] and 67% for *Staph. aureus* (76 of 113 patients).[3,4,6,7] It is this wide spectrum of activity which makes Gantanol (sulfamethoxazole) Suspension a good choice in acute pharyngitis, tonsillitis and otitis media.



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Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants or infants during first 3 months of life.

Warnings: Use only after critical appraisal in patients with liver damage, renal damage, urinary obstruction or blood dyscrasias. If toxic or hypersensitivity reactions or blood dyscrasias occur, discontinue therapy. In intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed. Data insufficient on prolonged or recurrent therapy in chronic renal diseases of children.

Precautions: Observe usual sulfonamide therapy precautions, including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus or rickettsial infections.

Adverse Reactions: Following may occur: headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, Stevens-Johnson syndrome, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Dosage: Children—1 teasp./20 lbs initially, followed by ½ teasp./20 lbs b.i.d. *Adults*—4 teasp. initially, followed by 2 teasp. b.i.d. or t.i.d., depending upon severity of infection.

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References: 1. Braden, B.; Colmore, J. P., and Cummings, M. M.: Antimicrobial Agents Annual—1960, p. 54. 2. Alban, J.: *Am. J. Dis. Child., 109*:304, 1965. 3. Elia, J. C.: *Eye Ear Nose & Throat Month., 41*:722, 1962. 4. Carter, C. H.: *Clin. Med., 71*:1571, 1964. 5. Jackson, H.; Cooper, J.; Mellinger, W. J., and Olsen, A. R.: *Southwestern Med., 44*:246, 1963. 6. Reichelderfer, T. E.: *Clin. Med., 71*:1045, 1964. 7. Peters, J. H.: Scientific Exhibit presented at the Spring Meeting of the American Academy of Pediatrics, April 26-29, 1965. 8. Peters, J. H.: Antimicrobial Agents and Chemotherapy—1961, p. 406. 9. Braden, B., and Colmore, J. P.: *J. Oklahoma M. A., 57*:7, 1964. 10. Chastain, P. J.: *J. Florida M. A., 48*:816, 1962. 11. Grater, W. C.: *Antibiotics & Chemother., 12*:450, 1962. 12. Exline, A. L.: *Colorado GP, 5*:(5), 11, 1963. 13. Patton, J. M.: *West. Med., 5*:46, 1964.

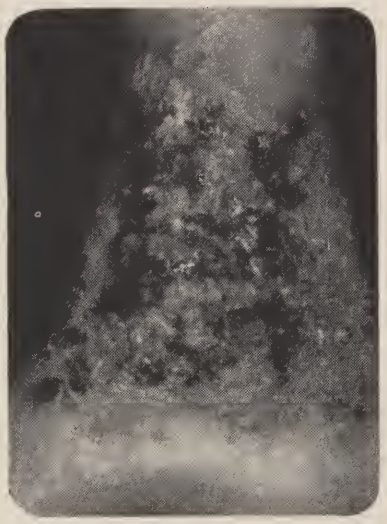
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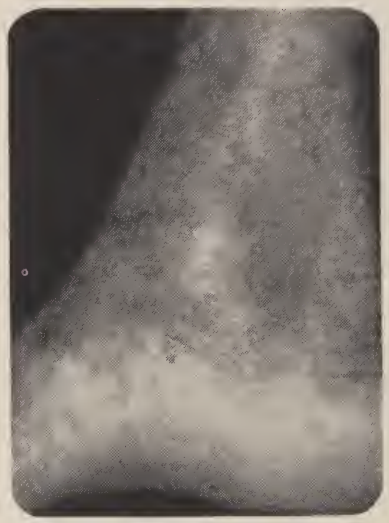
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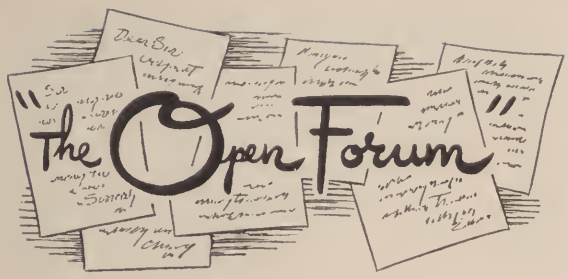
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To the Editor:

Because of recent bitter accusations made against the practice of medicine to graduating students, with resulting acrimonious responses, I suggest that you republish an address, entitled "Problems of Practice," delivered in Baltimore in 1952 by the late W. Edward Gallie of Toronto, who was professor of surgery and dean of the Faculty of Medicine at the University of Toronto. It was first published in the *Maryland State Medical Journal* in July 1952.

To me, this address of Dr. Gallie represents the attitude and hopes of the vast majority of those engaged in the private practice of medicine today. In this connection, it has been my stated opinion for many years that something drastic has to be done to reduce the dreadful, and continually rising cost of illness to the patient who has no insurance. We are all familiar with the so-called catastrophic illness, the cost of which may mean the sacrifice of the education of a child, a mortgaged home, the wiping out of the savings account of a life-time. I have believed for many years that the American Medical Association has been remiss in not recognizing the urgency of this problem. Some of this fault lies with those of us who may see the light but are unwilling to attend meetings and stand for elections in political medical affairs; more of the fault is because most of us have not taken the time to study the socioeconomic side of medical practice and taken measures to ease its ever increasing burden on the patient.

Unfortunately, the doctor gets the full blame for this cost, whereas it is, in reality, not the doctor's fee but the ever rising hospitalization charges which have brought us to the present crisis. By and large, the doctors' fees are fair and have increased very little in the last twenty years. There are some doctors, just as there are some individuals in any profession or business, whose charges are unfair and a hardship to the patient, but these doctors are few. The overwhelming majority of those practicing medicine in this country are dedicated individuals who treat the patients who can pay no fee just the same as those who can pay for their care.

The reasons for the ever increasing costs of hospitalization are many, but mainly due to the increase in salaries of all categories of the personnel in a hospital. I am told that 66⅔% of the expense budget of a hospital is due to personnel costs as opposed to 20% in an ordinary business. Added to a continuous increase in salaries and in unavoidable fixed costs, is the universal attitude of complete indifference toward avoiding or reducing avoidable costs. The size of yearly imbalance of a budget is no longer important, the increasing tint of the redness of the ink reflects an inefficiency of no real consequence. The deficit will be made up somehow by increasing again the daily rates to the patient and by asking "the Government" for some grant. In this age of packaged discards, all goods are expendable and are to be used with no thought of waste. How foolish, for example, is the old idea that in the surgical operating rooms one hesitated to break open unnecessary tubes of suture material, or that one hesitated to use up a whole roll of adhesive tape when a bandage properly applied would suffice. Electric lights are *not* made to be turned off when not in use.

The resident house staff is encouraged to believe that the efficiency of an individual member is in accordance with the number of tests and examinations ordered on every patient, however unnecessary. The rooms of the Executive and Administrative Staffs must all be paneled, air conditioned and have wall-to-wall carpeting. Economy as a means of reducing debt is just old fashioned, completely out of date.

How are the expenses of hospitalization to the individual patient to be reduced? The physician can help greatly by treating patients in his office or in their homes when possible and by refraining from ordering unnecessary examinations and tests when the patient is in the hospital. However, even such measures will in no way suffice to relieve the awful cost of necessary hospitalization. "Medicare" for those over 65 years has been an inevitable result of our indifference. A far better

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scheme at less cost to the patient and to the general public could have been worked out if we had started earlier. If we are to forestall completely socialized medicine in the United States we must face up to the problem without further delay.

Some greatly broadened base of hospital insurance is necessary. It is my belief that this base should be that of the private insurance companies, including the Blue Cross and Blue Shield; and that the medical profession, with its marvelous record in the conquest of disease under the free enterprise system, should not be pushed around in the future by bureaucrats and civil servants of socialized medicine. In many cases it may be necessary for the Federal and State Governments to help out in the payment of the insurance premium, but we have the brains and the ingenuity in this country to work out the necessary actuarial figures without destroying what has placed us at the pinnacle of medical discovery and treatment.

Finally, I see nothing un-American or wrong with a system whereby, if one works and studies harder and longer, he is rewarded by being able to live a little more comfortably, to educate his children a little better, to give his family a little more security.

Quoting from Dr. Gallie, I will conclude by saying that "in searching for means of reducing the cost of illness what folly it would be to destroy the goodwill of the doctors and to make them sorry they have ever come into the profession. The spectacle of what is going on in England and New Zealand, with their schemes of state medicine, is quite enough to drive bright and clever young men into other fields of endeavour. At any rate, there will be no sons of doctors entering medical school if state medicine comes. I would venture to predict that with the advent of socialized medicine, as it is advocated by the liberal, by the socialist and by the communist parties, this golden age of medical discovery will come to a close and we shall enter a period when progress in the study of health and disease will bog down to the speed of the civil service. The idea that medical research can be kept alive by government grants is just silly if it turns out, as I think it will, that the bright boys will no longer want to be doctors and will no longer enter the schools."

I. Ridgeway Trimble, MD

(Dr. Trimble is president of the Johns Hopkins Medical and Surgical Association. In accordance with his suggestion, "Problems of Practice" will be reprinted in the February issue of The Journal. Ed.)

DOCTORS TOP LIST IN PUBLIC ESTEEM

Doctors head the list of major professions and occupations, according to a *Newsweek* magazine survey of the professions and public esteem.

The study by Louis Harris and Associates showed 74% of Americans have a "great deal of confidence" in doctors. This is the highest rating received by any of the 17 professional groups listed.

Scoring lowest are those in the communications industries and labor leaders.

The results were drawn from a demographically representative sample of 2,000 individuals throughout the nation as part of a study into the public's attitude toward the business community and its practices.

The occupations and their "confidence scores:"

Doctors 74%
Bankers 70%
Scientists 66%
Military Leaders 65%
Educators 62%
Corporate heads 58%
Psychiatrists 57%
U. S. Supreme Court judges 54%
Local retailers 50%
Clergy 45%
Congressmen 44%
Federal government leaders 44%
Reporters, publishers 30%
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The AMA News, Nov 14, 1966.


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Editorial

THE BASIC REASON

In the past years most physicians have preferred to abstain altogether from politics and have left this area to professional politicians. If the latter were as competent in their actions as, on occasion, they would have us believe we are *not* in ours, this idyllic state might have persisted. Unfortunately, reality is hard upon us and there is no recourse but for some of us to carry our joint views into the political battle-field in a coordinated manner. In this fashion, we can make our opinions heard and our combined strength felt.

Herein lies the reason for the formation of the Maryland Medical Political Action Committee. A voluntary, non-profit, unincorporated group of physicians, their wives and other interested persons, the MMPAC has a dual purpose: to enhance the political knowledge of its members and to provide them with a means of concerted political action.

Let this fact be firmly clarified: we are not affiliated with any specific party. We select and support an individual candidate on the basis of his program and his platform, not his party affiliation.

Let another fact be clear: we function independently of the Medical and Chirurgical Faculty of the State of Maryland. While the Faculty is free to contribute to MMPAC, it may do so only for educational, and not for political, activities.

For the benefit of those who have inquired about the inclusion of MMPAC dues on bills for 1967 Faculty dues, it should be noted that the Executive Committee and the Council of the Medical and Chirurgical Faculty voted for the inclusion of MMPAC dues, which are payable on a voluntary basis, provided that the format and the content of the bills rendered met all legal requirements. On advice of legal counsel, it was determined that the costs of printing and of handling these contribution requests should be borne by MMPAC.

The Executive Committee and the Council also ruled that MMPAC dues should be shown on Faculty bills as a line item in a manner similar to that of itemizing the present voluntary contribution to AMA-ERF.

Now that the time for paying our annual dues has arrived, we hope every Maryland physician will look deep into his political conscience and clearly see his way to help MMPAC obtain the goals for which it was designed. We firmly believe that by helping this Committee, he will also aid the medical profession as a whole.

Joseph H. Hooper, Jr., MD
Chairman, MMPAC Executive Committee

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SEMINAR ON THE MEDICAL ASPECTS OF TRAFFIC SAFETY

The Seminar on the Medical Aspects of Traffic Safety was held in Baltimore on October 12, 1966, under the joint auspices of the Medical and Chirurgical Faculty of the State of Maryland and the Maryland Chapter of the American College of Surgeons. The subjects of four talks in the morning session were also the subjects of four workshops in the afternoon session, which ended with a summation of workshop conclusions. At an intermediate luncheon, the three principal gubernatorial candidates in the 1966 State elections expressed their opinions of appropriate legislation needed in Maryland to reduce the State's ever-increasing traffic fatalities.

Following an introduction by John E. Miller, MD, president of the Maryland Chapter of ACS, one of the co-sponsors of the Seminar, and "Words of Welcome" to the Seminar from the Honorable J. Millard Tawes, Governor of the State of Maryland, the four morning talks are presented here in their entirety. The subjects and the speakers, in the order of presentation, are:

The Role of Alcohol in Traffic Fatalities in Maryland—Russell S. Fisher, MD

Drugs and Driving—John C. Krantz, PhD

Medical Conditions and Driving Ability—A. J. Mirkin, MD, FACS

Legal Problems Involved in the Development of Legislation—J. Dudley Digges, Chief Judge

Traffic Safety: An Introduction

JOHN E. MILLER, MD

President, Maryland Chapter, American College of Surgeons

Accidental injury constitutes one of the biggest of today's health problems and ranks third, behind cardiovascular diseases and cancer, as a cause of death in this country. Automobile accidents result in more than 50,000 deaths and 4 million injuries each year, and are the first cause of death among young people between the ages of 15 and 24.

Across the nation, the number of deaths due to such accidents increased by 17% in 1964 and again in 1965. In Maryland, according to the Maryland Traffic Safety Commission, 747 deaths due to traffic accidents in 1966 had occurred as of January 2, a figure already in excess of the official count of 698 for the previous year and likely to be higher, because of delayed deaths, by the cut-off date of March 15. The total injured,

and the disabilities of survivors, with consequent economic loss, cannot be accurately evaluated because of the lack of statistics due to deficiencies in reporting by various treatment facilities. It is estimated, however, that the national cost of 1965 motor vehicle accidents was $8.2 billion and that the comparable figure for Maryland was $102 million.

That the automobile has created a major health and economic problem, needful of control, is thus obvious. Nevertheless, until recently, national traffic safety standards were established by the automotive industry and it is unrealistic to think they would encourage driver restrictions and/or vehicle alterations that might be costly and, at the same time, would eliminate many of the appealing features that helped them establish new national sales records. It is only in the past year that the public outcry has been great enough to force the automobile industry into certain structural automotive changes. The result of this has reflected on the national economy as a whole and pinpoints the difficulty of trying to establish controls in an industry that has become a major staple item of the economy. Because of its very bigness, it will perhaps bow only to federal control. However, the fact that relief can be obtained by the appropriate cooperative action of interested and involved parties has been amply demonstrated in industry, another example being the problem of suffocation deaths in refrigerators.

Medical science has made great progress in the prevention of death and disability in the treatment of the injured. The effectiveness of this is demonstrated by the mortality rate of approximately 4% of the injured treated in the Vietnam war, though comparative statistics for automobile-accident injury are not available. Continuing progress is being made in medical science in the treatment of the injured, but it is obvious that improvement here will have little effect on the over-all salvage. The United States Public Health Service, the American Medical Association and the National Safety Council combined in a public education program to promote acceptance and availability of seat belts in the United States and thus significantly reduced the estimated 25% of fatalities caused by ejection from the vehicle.

In Maryland, in order to expedite the transfer of the patient from the accident scene to the hospital, and to ensure his arrival there in the best possible condition, the names and locations of nearest hospitals have been posted along major roadways and, with the help of the Medical and Chirurgical Faculty, a training program for ambulance crews has been established. The Faculty has also recommended that some thought be given to licensing ambulance attendants so that minimum standards of training will be required.

For the physician to do more it is obvious that his efforts must be extended to the factors involved in accidents, and it would seem that throughout the history of medicine it is in the role of *prevention* that the physician's efforts have been most rewarded.

Of the three factors involved in automobile accidents (driver, vehicle, and road environment), the driver is regarded by most authorities as the principal cause. It is the young male driver who is most frequently involved. It seems that just at the age when the young male is bursting at the seams to release his aggressive tendencies, and usually after minimal training, he is given a license to drive a high powered car on high speed highways where restraining bonds are not as evident and where he can give vent to these tendencies.

It has been estimated that to drive a car today requires satisfactory resolution of 20 to 60 decisions each mile. The older driver, whose reflexes are not as good in the modern maze of high speed highways, is equally at a disadvantage. A recent study indicates that drivers with medical conditions who are 60 years of age or over have almost twice as many accidents per million miles of driving as all drivers under that age. In this same study, drivers with medical conditions are generally shown to have a higher accident and/or violation rate than drivers without medical conditions.

The medical literature is replete with accidents due to drug intoxication. The major intoxicant is alcohol. The true extent of its damaging effects is not known, but it has been shown that the blood-alcohol level was moderate or greater in approximately 40% of the driver fatalities in the nation.

So that additional factual information related to this problem would be available, and appropriate action might then be expected from responsible agencies, the Medical and Chirurgical Faculty supported enactment of the implied consent law, unsuccessfully, by the 1966 Legislature. There are many contributing elements which render a person

an unsafe driver from the medical viewpoint, but there are not sufficient well-controlled studies to pinpoint the exact contribution of each so that proper action for control can be advised.

Physicians have been reluctant to participate actively in the formulating of decisions that might encroach on the historic medical right of privileged communication between patient and physician, especially where the appropriate action for community-health benefit might oppose that of individual-health benefit. Nevertheless, the medical profession set a precedent in its treatment and prevention of infectious diseases by establishing the fact that individual health is best achieved with community-health improvement. Standards such as this required physician recommendation for adoption by legislative action. Similar legislation was recently enacted in an attempt to control child beating. Medicine must now come to the fore again and evaluate one of our major health problems as it pertains to the medical aspects of highway safety.

There has been much to do recently in the establishment of major health centers for research and treatment of cardiovascular diseases, cancer and emphysema—to the last of which the by-products of the automobile are contributing factors. This work has been strongly supported by the medical profession, prominent public officials, mass news media and various government agencies. In contrast, the position of a national director for automobile safety and accident prevention has only recently been established, and government research figures for 1965 reveal that $16.5 million was allocated for traffic-accident prevention as compared with total expenditures for medical, health and related research of approximately $1.85 billion. Much more needs to be done in research of highway traffic accidents, and appropriate budgetary allotment is a necessity.

The automobile is a requisite of today's life and although it is defiant of control, like all other major health problems it will nevertheless lend itself to conciliation when a concerted effort is made by responsible agencies, the public, the automobile industry itself, and the physician. The Medical and Chirurgical Faculty and the Maryland Chapter of the American College of Surgeons, together with other interested non-medical groups planned this Seminar, with its evaluation of the medical aspects of traffic safety, in the belief that it will lead to better understanding of the problem and thence to effective controls, legislative and otherwise.

Words of Welcome

J. MILLARD TAWES

Governor of the State of Maryland

May I begin by expressing my gratitude, and the gratitude of the people of Maryland, to the Medical and Chirurgical Faculty of the State of Maryland and the Maryland Chapter of the American College of Surgeons for conceiving, planning and executing this important Seminar on the Medical Aspects of Traffic Safety.

I have looked at your program for the day, and I am profoundly impressed, both by the caliber of the discussion leaders and by the subjects which will be discussed at this seminar.

I hope to receive a full account of the proceedings, and I hope that groups which I have chosen to study and try to find a solution to this immense social problem will take advantage of the ideas that will be discussed here and the suggestions that will be proposed by your group.

Certainly we have here in this assembly the talent and the experience to provide an insight into such problems as those created by the motorist who drives while under the influence of alcohol or drugs.

As you know, these drivers are the chief contributors to the prevalence of highway accidents and the frightful toll they take in killings, maimings and the useless destruction of property.

Being practical people, we are aware that there probably exist no means or measures by which we may expect a total elimination of highway accidents. We, nevertheless, must not relax in our efforts to reduce the mishaps, and, just as you are doing here today, continue to work unstintingly to develop the best possible weapon to fight this growing social evil.

As I have said so many times, highway safety is a joint responsibility of government and of citizens, acting either as individuals or collectively, as is the case with this group. Government should provide the leadership, but it cannot do the task alone. That is why discussion groups such as are assembled here today are so important in the over-all effort we are making in Maryland to reduce accidents.

Last June, I established a new position on my staff, the position of Executive Assistant for Traffic Safety, and named to the position Mr. William Prescott Allen, publisher of the *Bethesda-Chevy Chase Tribune*.

At the same time, I established a Traffic Safety Advisory Council, designating Mr. Allen as chairman, and including in its membership Colonel Carey Jarman, superintendent of the Maryland State Police; John R. Jewell, Commissioner of Motor Vehicles; and John B. Funk, chairman-director of the State Roads Commission.

My instruction to the council was that it coordinate all suggestions and recommendations for the improvment of safety on the highways of Maryland and that it develop a highway safety program for the State designed to attack every facet of the traffic safety problem.

I am told that this group has been in close touch with the Medical and Chirurgical Faculty and that it has received valuable assistance from the members of that organization.

Also, I instructed the council that it was to be responsible for developing a safety program that will assure the full participation by the State of Maryland in funds available under the provisions of the Federal Highway Safety Act of 1966 and in other highway safety programs which the Federal Government may develop.

At the session of the General Assembly earlier this year, more than 100 bills relating to traffic safety were introduced, and I am told that the sheer number of bills alone was a factor in the failure of the legislature to produce an effective program of traffic safety.

This is one of the reasons why I asked the Advisory Council to develop a comprehensive legislative program, representing the best thinking of groups such as this on the subject.

I am advised that the complete program of legislative proposals, in bill form, will be ready next week.

I know that all of you here are as disappointed as I am with the traffic accident record that is being written in Maryland this year. In fatalities, in injuries and in the number of accidents, we are running far ahead of last year. Last year itself was much worse than the year before.

This, of course, is not a condition which exists in Maryland alone. In the country as a whole, traffic accidents cost the lives of more than 50,000 persons each year, and the figure climbs with each successive year.

It is poor consolation, however, that other areas of the country are as bad as we are, or worse. Our concern is that many hundreds of persons are killed on the highways of our State each year, and that the number of persons injured in accidents is many times more than that.

We must not be discouraged, however, by the enormity of the problem. We must not relax our efforts simply because ours is a problem that defies solution. We must, on the contrary, work harder, because any betterment of conditions means the saving of precious human lives.

That is why it is so gratifying to me, as the chief executive of the State, to witness this display of selfless, public-spirited concern for the safety and the well-being of the people of Maryland.

Again, please accept my commendation for your efforts, and with it my deep appreciation for the assistance you are offering in the gigantic task of making the highways of Maryland safer for our own citizens and for those who visit our beloved State.

The Role of Alcohol in Traffic Fatalities in Maryland

RUSSELL S. FISHER, MD
Chief Medical Examiner
State of Maryland
Department of Post Mortem Examiners

Before I show some of the grim statistics of traffic deaths due to driving while under the influence of alcohol, I would like to make a plea to those here who represent the public communications media to enter into the spirit of affirmative traffic safety education and accident prevention. By this I mean that, as in the case of the ten commandments, most of which begin, "Thou shalt not . . ." (for example, you shall not drive under the influence of alcohol, and you shall not drive carelessly), there is one greater commandment that boils down, as the Lord said, to, "Love thy neighbor as thyself."

This is affirmative. It gives us something good to do instead of a lot of "thou shalt nots." I think if we are to solve the murder-on-the-highway traffic problem, it will take more than the police and the medical examiner, the State's Attorney and the courts, in the thou-shalt-not phase. It will take an active educational program on your part and on the part of all those who have access to the public mind, a program which does not merely say, "Thou shalt not drive carelessly," but which teaches us to drive safely.

Having indicated, therefore, that I think what can be done in prevention by legal enforcement is but a small part of what we need, I will do what I was asked to do here today: explain to you or show you some of the evidence that indicates that one medical condition, namely, an excess of alcohol in the system, is an important factor in the deaths that occur on our highways.

If we look at the scale on the left of the Figure, we can get some idea of the relationship of the level of alcohol in the system to our ability to be safe drivers. This slide shows blood-alcohol concentrations in actual percentages. Thus at the top we are dealing with one-half of one percent of alcohol in the blood. Fifteen hundredths of one



percent is the level which, for many years, has been accepted as the absolute maximal blood-alcohol concentration for an individual still to be reasonably able to drive an automobile.

Indeed, as a result of studies in the past few years, all the national groups, including the American Medical Association and the National Safety Council, and all experts in the alcohol and chemical testing fields, have agreed that only one-tenth of one percent is the level above which drivers are unfavorably influenced in their ability to control a vehicle. So we say, with no hesitation, it is highly probable that the individual is "under the influence" in the range of 0.10% to 0.15%, and it is certain that he is under the influence if his blood-alcohol level is above fifteen hundredths of one percent.

In Maryland, by law, one is presumed to be under the influence if his blood-alcohol level is shown to be fifteen hundredths of one percent or greater. Bearing these figures in mind, let us look at Table 1, which presents actual statistics for this State.

In 1965 there were 274 drivers killed in motor vehicle accidents on Maryland highways. It is part of the Medical Examiner's job to test the individuals who die as a result of violent death in motor vehicles to determine whether the driver had been drinking significantly.

Some drivers survive a number of hours or days after accidents and any alcohol present in the system at the time of accident would have been burned out by the time of death; these drivers are therefore not tested. When individuals die immediately, or within a few hours, their blood-alcohol level is automatically checked.

ALCOHOL ANALYSES IN MOTOR VEHICLE FATALITIES—1965

Drivers Involved in Fatal Accidents		846
Drivers Killed		274
Number of Driver Fatalities Analyzed		149
Results of Analysis of Blood		% of total tested
Negative	51	34
.01%- .05%	6	4
0.06%-0.09%	12	8
0.10%-0.14%	26	18
0.15% or more	54	36

Table 1

Of the 274 drivers who died in 1965, 149 were checked by our department. Reduced to percentages, reports on the tested drivers were negative for 34%: they had not been drinking. Another 4% had not been drinking significantly; they may have had a cocktail. We do not believe they were under the influence. There is another 8% who were in the low range, and it is difficult to say with any certainty that their behavior was influenced.

But there was a total of 18% whose blood-alcohol level was in excess of .10% and there were 36% in whom it exceeded .15%—a total of 54%, more than half of all the drivers tested after being killed on highways.

You may say, "Doctor, how do you know that the alcohol level which was evaluated had anything to do with their deaths?" I must admit this is a little difficult to prove, but I think you will agree with me that half of all the people driving the highways in the State of Maryland are not carrying blood-alcohol levels of above .10%. You would have to assume that would be equally true if you disagreed with me in the conclusion that the alcohol had something to do with their deaths. There has to be a relationship between this high concentration of alcohol and the extremely high proportion of drivers who were involved, and indeed killed, in fatal automobile accidents.

It is obviously true of course that, in addition to this 54%, some of the individuals who were killed, were killed by drunken drivers who did not happen to get killed and tested themselves. So the conclusion that more than half the drivers who met their deaths in vehicular accidents were, in some degree at least, victims of alcohol seems highly supported.

Table 2 takes us to the question of testing the non-fatal individuals on the road whose driving is thought by the police at the time of their arrest to indicate they are under the influence of alcohol. In 1965, there were 663 drivers tested by the Maryland State Police under their breathalyzer testing program. Some 83% turned out to have .15% or more blood-alcohol. This means that the police, as a result of their experience in apprehending these individuals, believed when they saw them that they were under the influence; they asked them to take the test; the test was taken and it corroborated their original impression in 83% of the cases. Indeed, with the addition of another 12% of the 663 whose blood-alcohol was at the .10% to .14% level, there were actually 95% who had been imbibing significantly, so that there seems no doubt their ability to operate a vehicle was impaired.

RESULTS OF BREATHALYZER TESTS BY MARYLAND STATE POLICE—1965

Blood Alcohol	Number	Percent of Total
.05% or less	17	3
.06% to .09%	13	2
.10% to .14%	82	12
.15% or above	551	83
Total	663	100

Table 2

Obviously this information is useful in prosecution. It does help the police in their efforts to keep the drunken driver off the road. So why are we not doing better? Table 3, I think, answers the question very promptly.

We are not doing better with the chemical test law, which is certainly one of the tools in law enforcement in these cases, for the prime reason that of all people who were asked to take the test, (the law requires that the test must be offered on

a voluntary basis), more than 40% refused. They did not cooperate with the police in providing evidence that indeed they were under the influence of alcohol, or were not, as the case may be.

BREATHALYZER TESTS BY MARYLAND STATE POLICE—1965

Tests Offered	1114
Tests Given	663
Tests Refused	451
Percentage of Refusals	40%

Table 3

I would mention very briefly, before we leave the subject, the 5% of individuals who were tested, and whose tests were negative. This is a side effect, you might say, a side benefit of the law—because it is important to "follow through" when an individual appears to be inebriated, and the chemical tests reveal that he in fact is not drinking at all. Obviously he is medically ill; there must be some other explanation of his apparent drunkenness. Of course these people end up in the hands of physicians who then treat their diabetes, or their drug intoxication, or whatever it may be that was misinterpreted as evidence of their being under the influence. This is simply a safety factor in protecting the non-involved individuals.

I want to go back to this for a minute because there has been a bill before the State Legislature for several years which would provide for what we call "implied consent." If this were enacted, individuals who refused to take the test after having been arrested and charged with driving while under the influence, would be subject to loss of their driver's license for a certain period. If one is to make the chemical test program effective as a means of discouraging driving while under the influence of alcohol, one must have a mechanism for using the test in all the cases in which the question has been raised. As it stands now, with 40% of the suspects refusing the test, the mechanism of prosecution is largely inactivated.

The police, the Medical Examiner, most individuals who are safety minded, believe that the implied consent law, which would subject the individual who refuses to take the test to at least a period when he would not be driving on the highways, is a good law, and one that we should have. We will not take the time to discuss it further here today, but I think it is important for all of you to recognize that part of the problem of vehicular accidents and deaths due to alcohol is enforcement, and part of the failure of enforcement is due to the inadequacy of the laws which provide the police with the tools for enforcement of the ban on driving while under the influence.

I have little more to add. I would summarize this simply by saying that there have been many studies of alcohol and driving. Our own experience through the years indicates that the figures I showed you for 1965 are about the same as they were ten years ago. Between a third and a half of the drivers killed on the highways are under the influence; between a third and a half of the pedestrians killed have a high blood-alcohol level at the time they are struck; and even a good many of the passengers are under the influence at the time they are killed.

I can present the business of the pedestrian a little bit differently because basically you can divide the pedestrians into three groups. There are children who, foolishly and because they are children, jump out in front of automobiles. Of course the children have not been drinking. There is an elderly group—and I will not attempt to define that in years because each year "elderly" gets older than it used to be—and the elderly people are hard of hearing, or have visual deficiencies, or are impaired physically, so that they cannot dodge the oncoming car very effectively, and it is our experience that among these people about 25% to 35% will also have been drinking when they are hit as pedestrians.

The children make up about one-third of the victims, the elderly people about one-third of the victims, and then there is what we call a middle third, the people perhaps between fifteen years at the youngest and some ripe old age at the top. This middle third are of special concern to us because we wonder why should they be killed. I will tell you why: two-thirds of them are under the influence of alcohol at the time they are hit by an automobile.

I am convinced that alcohol has something to do with motor vehicle deaths. I believe that this opinion is held by all of the doctors in the State, and I hope whatever medicine can do to help curb this excessive use of alcohol, and thereby help to prevent the carnage on the highway, we will do.

Drugs and Driving

JOHN C. KRANTZ, JR., PhD
Professor Emeritus of Pharmacology
University of Maryland School of Medicine

It seems trite to say that we have entered into a mechanical age, and that the tempo of life has materially increased. If our forebears missed a stagecoach, they were rather happy about it; it gave them several hours of relaxation and rest awaiting the arrival of the next coach. We, however, have increased the tempo of our lives to such an extent that we let out an oath if we miss a slot in a revolving door.

We often create a great deal of motion without too much sense of direction. An astute observer of our generation has said, "To preserve a man alive in the midst of so many changes and hostilities is almost as great a miracle as creating him."

The pace of the mechanical age has produced a symptom in our emotional life, and that symptom is anxiety. Anxiety resembles a fleece-like fog that envelops an individual. It begins nowhere, it ends nowhere; it has no perimeter. It engulfs the individual and takes away his self-confidence.

In order to regain his self-confidence and emotional stability, the individual takes recourse to drugs. We are a drug-taking nation. Taking drugs is a favorite American pastime. Osler said, "The great difference between man and other primates is that man likes to take drugs."

Fortunately for the human race, within the last decade the pharmacologists have made a frontal attack upon emotional instability, thinking disturbances and anxiety. This frontal attack has brought us a class of drugs commonly referred to as tranquilizers or psychotropic drugs. These drugs affect the mood and thinking of the individual.

It is abundantly clear if a drug is going to affect the thinking of an individual, it is going to affect his operation of a motor vehicle. Let us then consider some of the classes of drugs which people take in abundance, and how they may affect the driving skill of an individual.

There are the analgesics. What does this mean?—pain-killers. Pain is a tax that is levied on everyone as the price of life on this planet. Some persons are taxed heavily and others lightly, but all are taxed. One of the great pain-relieving drugs that we take in abundance in America is the miracle drug of the turn of the century, aspirin. How much? Daily the American public ingests 37 tons of aspirin. So we really like this drug.

Fortunately, aspirin has its effect in relieving what we call integumental pain—muscle pain, neuritis and neuromuscular pain in general. It acts in the thalamus and the periphery, and does not affect the cerebral cortex, the area of the brain concerned with thinking. Therefore, for almost everyone, the taking of aspirin and the operating of an automobile are perfectly compatible.

On the other hand, aspirin does not relieve deep visceral pain, the pain, for example, of a kidney stone or of peptic ulcer. For these types of pain one must take recourse to narcotic drugs such as morphine or meperidine. These drugs do affect the cerebral cortex. They elevate the threshold of pain; they produce a false euphoria. They disassociate the individual from his environment. They isolate him from his surroundings, and certainly a person under the influence of one of these analgesic drugs should not operate a motor vehicle.

The next class of drugs is represented by the hypnotics. Insomnia is one of the products of our age. Phenobarbital, developed in 1912, is an excellent drug. It is used not only for insomnia but for daytime sedation, and also to quell anxiety, the emotional overhang of certain types of diseases such as peptic ulcer, hypertention and angina pectoris.

Phenobarbital is a very popular drug among the members of the medical profession. We ingest approximately one ton of phenobarbital every day. Certain individuals can take phenobarbital and operate a motor vehicle without performance impairment. One should be warned, however, that it may make him drowsy, that phenobarbital is a sedative drug, and that if one takes phenobarbital and simultaneously ingests alcohol, the action of the two is synergistic and may produce a very definite driving hazard.

To induce sleep at night, phenobarbital is not the drug of choice, but one of the so-called short-acting barbiturate derivatives. Among these are

pentobarbital (Nembutal®) and secobarbital (Seconal®); these drugs act more promptly and for a shorter period of time. They are much better for producing sleep in the evening. One should be very careful, in prescribing these drugs for insomnia, not to give the patient who has difficulty in getting to sleep a long-acting barbiturate like phenobarbital. Phenobarbital evokes nocturnal sleep but when one awakens in the morning, his awareness is blurred. He is then thrust out into the traffic of the expressway when his judgment is impaired by the effect of the drug that has not yet worn off. Doctors know that this can be avoided by the use of Seconal® or Nembutal®, as I have already suggested.

We have discussed some of the depressants to the central nervous system. Let us now consider some of the stimulants to the central nervous system. The old and time-honored caffeine is an excellent stimulant. It, of course is present in coffee and in tea. People have often wondered: does caffeine stimulate the ability of the muscle to contract and thus provide more strength and power? No. It lifts the mood, it stimulates the spirit; it is a psychic stimulant.

In 1938, when the Olympic Games were held in Berlin, Eichler studied the effect of caffeine on the performance of several of the athletes. In the hundred-meter sprint, where judgment was not required and only speed of running was involved, caffeine had no effect. But in shotput, high jumping and broad jumping, caffeine had a definite effect, improving the performance.

Furthermore there seems to be no backlash from caffeine. There is no feeling of letdown after its effects have worn off; ingested in coffee and tea, it is therefore perfectly compatible with driving a motor vehicle.

There are other types of stimulants, for example amphetamine (Dexedrine®). How does this act? It is a "benny." It superimposes a hyperexcitability over fatigue and gives rise to restlessness, irresponsibility and lack of judgment. It is therefore certainly incompatible with driving.

The same type of drug is used to curb the appetite—and those who are fighting the battle of the bulge often take such drugs. The small doses recommended to curb appetite, if not abused, will have no effect on the central nervous system, hence hyperexcitability and recklessness will not be present.

In the last three or four years another class of stimulants to the central-nervous system, known as anti-depressants, has been introduced in the field of psychiatry. Imipramine (Tofranil®) and amitriptyline (Elavil®) are drugs of this class. They lift the mood of the patient in severe melancholia. These drugs are not capable of producing hyperexcitability, but if they are given and alcohol is ingested, the two will act as synergists and not only will there be hyperexcitability and distortion of the thinking process, but also an impairment of the motor functions of the body. It is clear that driving under these conditions would be hazardous.

We come now to consideration of the antihistaminic drugs. We have had these for about twenty years. These drugs are for the most part anticholinergic drugs, which means drugs similar to belladonna. One is familiar with what happens when the physician refracts the eyes for glasses by instilling a belladonna preparation. It blurs the vision. Many of these antihistaminic drugs will do precisely the same thing, and a blurred vision of course is incompatible with driving.

But, in addition, there is another effect, and that is drowsiness. This is largely individualistic. Certain people can take the antihistaminic drugs—diphenhydramine (Benadryl®), tripelennamine (Pyribenzamine®), and chlorprophenpyridamine (Chlortrimeton®)—and have no drowsiness whatsoever, whereas others have very marked drowsiness, and this of course would add a blurred consciousness to a blurred vision, each of which would be incompatible with driving.

These antihistaminic drugs also have been used as anti-motion sickness drugs, and the outstanding one of these of course is dimenhydrinate (Dramamine®). This, too, is anticholinergic and can produce a certain amount of drowsiness and blurred vision. Two better drugs for this purpose are meclizine (Bonine®) and cyclizine (Marezine®); they produce less drowsiness and less blurred vision.

The psychotropic drugs, or the tranquilizing drugs as most of you know them, are a product of our age. We divide them into two classes: the major ones which are called the antipsychotic drugs, of which chlorpromazine (Thorazine®) is the prototype, and then the so-called minor tranquilizer drugs, which consist of meprobamate (Miltown® and Equanil®), chloridazepoxide (Librium®), diazepam (Valium®), and certain others.

May I state that 80 million people have taken meprobamate, which number is comparable to all of the drivers of motor vehicles in the United States. If you add to this 80 million people who have taken Miltown®, those who have taken Librium®, Valium® and others, you can see that practically everyone who is operating an automobile has at one time or another, even when operating the automobile, taken some kind of psychotropic drug.

What are the effects of these drugs? The minor tranquilizers that are used to quell anxiety, and for daytime sedation, certainly have the capacity to slow the reflex time of an individual. In addition to that they tend to isolate him from his environment, and it is tragic for a person operating an automobile to get dreamy and drowsy and to become isolated from the traffic which encompasses him on the highway.

A few years ago I gave a telecast here in the city on the effect of alcohol on driving. One of my graduate students, Dr. Johnson Ling, was the test subject on the telecast. We set up an experiment in which Dr. Ling was to see a signal representing a car coming along a highway, and then he was to press the foot on the brake and stop the car which he was operating.

It generally took him about three-tenths of a second to do this. He was an uninitiated individual in drinking, and we gave him a long, hard gin and tonic, and then put him through the same experiment. The reflex time was doubled. It took him six-tenths of a second, after he saw the oncoming car on the highway, to push the brake in his car. In three-tenths of a second, going sixty miles an hour, a car can cover 26 feet on the highway—it is a matter of life or death.

The psychometric drugs—like the universal tranquilizer, alcohol—slow the reflex reaction time. Germane to this subject is an experiment which was carried out by investigators in Manchester, England. Some of the finest drivers of motor vehicles in the world operate the double-deck buses in England, and they were given a test in which they were to run a bus between two stakes and see if they could miss these stakes by one centimeter on either side. This is indeed a feat.

Without alcohol they could do this quite well. With alcohol their capacity deteriorated, but what deteriorated more than their skill was their judgment of what they could do and what they could not do. Their judgment of their ability to do this deteriorated far more than their performance of going through the narrow aisle that was set before them.

So it is obvious that the taking of this type of drug or alcohol is also incompatible with driving.

In conclusion, people should take, and physicians should prescribe, drugs that affect the central nervous system only when they are definitively indicated. The patient should be warned against the possibility of the drug affecting the central nervous system adversely, especially when the individual is operating a motor vehicle. One should always bear in mind that the response is individualistic. No one responds in exactly the same way as another to a drug which affects the central nervous system. We look upon these drugs with respect to the operation of a motor vehicle, and must concede that they are like the finger of God: they can heal and they can smite.

Medical Conditions and Driving Ability

ABRAHAM J. MIRKIN

Chairman, Committee on the Medical Aspects of Automotive Safety, American Medical Association

As you can see, the title of my presentation is not one of sterile clinical appearance. It was selected because Mr. Gordon Dalsemer of the National Safety Council thought that we should be addressing our remarks to lay people interested in traffic safety, rather than to physicians. We did not want to frighten off anyone.

I welcome this opportunity to speak to you who are non-medical because the medical profession has all too often been asked to delimit the relationship between physical or emotional factors and the causation of collisions. Unfortunately no aspect of traffic safety has been less clearly defined than how to assess the health status of an

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this issue: the nose as a shock organ

the nose as a shock organ

by Charles J. Shagoury, M.D., Chelmsford, Massachusetts



"Is it a cold, hay fever, or has he been reprimanded by his boss?" Occasionally, you will ask yourself this question when confronted by a patient with abrupt onset of rhinorrhea, nasal obstruction, and sneezing. Usually the history will elucidate the problem, but examination of the nose will often provide valuable clues to the correct diagnosis.

The nose is a shock organ in a double sense. First, it is in the nose that the confrontation takes place with the surrounding atmosphere. For twenty-four hours a day, the nose must meet the varying challenges of the inspired air, containing perhaps noxious chemicals, dust, dirt, bacteria, viruses, fungi, and industrial pollutants of all kinds, and render it clean, virtually sterile, and fit for the sensitive alveoli of the lungs. Whatever the temperature or humidity of the atmosphere, the nose must transmit it to the lungs at approximately 98°F, and with a humidity of approximately 40%.[1]

Second, in particularly susceptible patients, the nose acts as a shock organ in a manner totally unrelated to its normal function. Persons with hay fever respond to ordinarily harmless materials by extreme nasal congestion, with marked rhinorrhea and violent spasms of sneezing. In some patients, exposure to threatening or disagreeable agents, or situations involving mental conflict may result in a reaction which is exclusively nasal, with swelling of the turbinates, and marked hypersecretion.[2]

Nasal symptoms usually result when the nose seeks to perform its function of getting rid of noxious and dangerous elements in the atmosphere, and prevent their admission to the trachea and lungs. Small particles are removed by the mucous coating which blankets the nasal passages. This mucous blanket contains a bacteriostatic agent, lysozyme, which destroys most air-borne bacteria.[3] The mucinous content renders the surface sticky, causing dusts and small particles to adhere. It has been postulated that this process is rendered more effective through adsorption because of a surface electrical charge on the nasal mucosa.[4] The cilia then sweep the particulate matter to the pharynx. The nose can prevent entrance into the lungs of particles as small as three microns in diameter, but smaller particles elude the nasal barrier. Most bacteria causing respiratory infections are one to three microns in diameter, but since they usually are inhaled in clumps, they are efficiently removed as a rule. Viruses, which are of the order of 1/1000 of this size, are less efficiently dealt with, unless they occur in very large aggregates.[5]

The nose will react in a more or less similar manner, whatever the nature of the offending agent, whether it be an irritant chemical, virus, pollen, or distasteful emotional situation. In acute coryza, the most characteristic sign is a profuse watery discharge. The volume of secretion may rise from practically nothing to nearly 60cc in twenty-four hours.[6] The mucous membrane is reddened and engorged, while the turbinates are markedly swollen. After the first day or two, the secretion becomes thicker, yellowish, and more difficult to expel. The surface cells are largely destroyed, contributing to the copious discharge, which now also contains numerous inflammatory cells which have migrated to the area. Gradually, over a period of a few days, or a week, the flood abates, the swelling and redness subside, and the nasal epithelium resumes a healthy appearance.

Repeated attacks of rhinitis, particularly if there is an underlying element of obstruction, may result in chronic rhinitis. The mucous membrane is constantly swollen and reddened. Sticky, mucopurulent secretions are a continuous feature, and the glandular elements are hypertrophied. Commonly, the mucosal surface takes on an irregular, rounded "mulberry" appearance, and nasal passages are occluded by the swollen turbinates and redundant mucosa.

While all of us are susceptible to colds, the victim of hay fever, or allergic rhinitis, displays a marked nasal reaction to materials in the air which leave his associates unaffected. In such a patient, the nasal mucosa has become an allergic "shock" organ. Contact with the nasal allergen causes local release of histamine, with vasodilatation, increased vascular permeability, and severe nasal congestion, similar to the "wheal" and "flare" reactions in the skin, when the epidermis is the allergic shock organ. While we eagerly await the coming of spring, the hay fever sufferer dreads the blooming season, whose invisible pollens are poisons to his sensitive nose. His neighbor's cat or dog may provoke paroxysms of uncontrollable sneezing. In some cases a specific allergen is not identified, but the triad of rhinorrhea, nasal obstruction, and sneezing is present.[7] The nose in these cases shows a pale, boggy, edematous mucosa, with a thin mucoid secretion. The mucous membrane shows extreme retractility to 1% cocaine or ephedrine. If the patient has medicated himself prior to examination, the nasal passages may appear abnormally patent, or show exaggerated congestion due to rebound reaction. The secretion may show a large number of eosinophils particularly after an attack of sneezing or rhinorrhea. Touching the mucosal surface, especially of the inferior turbinate, leaves an indentation, showing that the swelling is due to stasis and edema, rather than actual hyperplasia of the mucous membrane as in chronic hypertrophic rhinitis. Though the pale swollen mucosa is the hallmark of allergic rhinitis, as usually seen by the physician, exposure of allergic subjects to their known allergens results in a brief hyperemic phase, followed by pallor and edema.[8]

In the later stages of allergic rhinitis, the chronic edema of the mucous membrane results in the formation of polyps, clusters of grape-like masses hanging from the roof of the nose, with a pale glistening surface, contributing significantly to the sense of nasal obstruction and oppression.

A large group of patients show symptoms of nasal congestion when confronted by adverse life situations.[9] In these unfortunate persons, anxiety, frustration, and resentment are often accompanied by a runny nose and nasal obstruction. Lacrimation adds to the nasal stuffiness. This autonomic response, mediated by the parasympathetic nervous system, may be part of a general parasympathetic reaction, or may possibly represent in part, a symbolic effort to wash out and crowd out the offending situation.

Nasal congestion may also occur in some patients at times of sexual stimulation, and in women during menstruation and pregnancy, even to the point of epistaxis.[10] The relationship is obscure; castration results in atrophy of the nasal glands, and their action is inhibited by the hormones of the hypophysis and the thyroid.[11] The nose may be the shock organ in drug therapy. The nose may also bear the brunt of industrial stress, in those who work in a hot dry atmosphere, or those exposed to acid fumes, or irritating dusts. As the air in our cities is increasingly polluted by exhaust fumes, and industrial irritants, whole urban populations may suffer from chronic nasal and respiratory symptoms.

Of course, nasal reactions are not just infectious, or allergic, or emotional. Particularly in the chronic sufferers, there is an interdependence of all three. Death of a relative, or other psychic shock can pre-

(concluded on following page)

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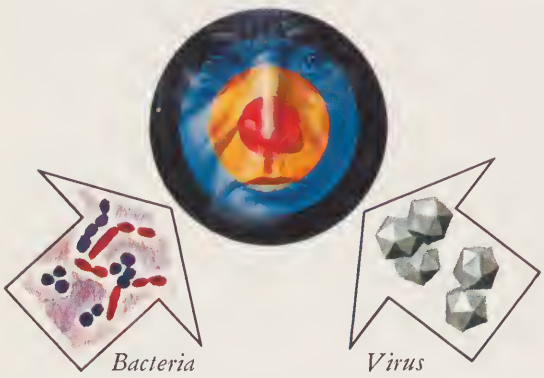
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cipitate an attack of rhinorrhea in hay fever sufferers.[12] Others develop attacks of vasomotor rhinitis following change in temperature, chilling, or exposure to the sun, or simply warm bedclothes.

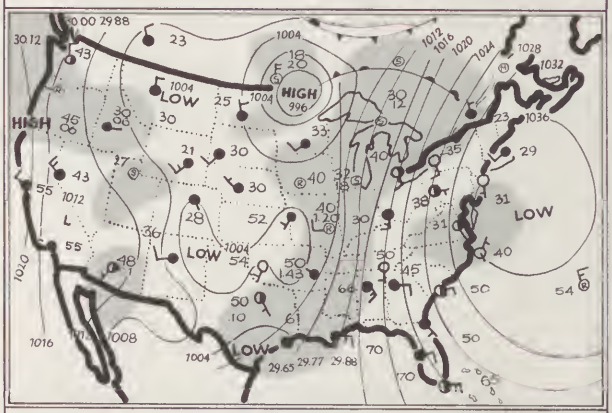


The complex interplay of allergy and infection is largely unclear. Allergy to the viruses and bacteria which cause infection has been postulated, but is difficult to demonstrate. The swollen obstructed allergic nose is more susceptible to infection. At the same time, infection often precedes or precipitates an allergic attack. Exposure of a susceptible patient to an allergen can activate latent virus organisms leading to infection.[13] This "jolt" reaction represents a summation of an allergen and a virus leading to symptoms in the nose as a shock organ, which neither could have produced alone. In childhood, repeated attacks of bronchitis and colds may be inflammatory reactions to an allergen, or precipitated by exposure to an allergen. These children may later develop typical allergic rhinitis. On the other hand, children with typical allergic histories, eczema, asthma, and allergic familial backgrounds, may later develop typical infectious rhinopathies. Skin tests in such patients are usually positive.

Nasal reactions are part of the systemic response of the patient to an unwelcome stimulus. In cases of respiratory infection and exposure to atmospheric irritants, the reactions are useful, and to some extent desirable. They are usually self-limited, disappearing within a few days, or upon removal of the provoking agent. Here the distressing symptoms can be ameliorated with appropriate decongestant agents, or, in the case of severe or complicated respiratory infections, antibiotics may be given, with reasonable confidence of a cure. On the other hand, when nasal reactions are the peculiar response of an individual to an allergen, or to an undesirable situation, they serve no useful purpose. The nose here is a shock organ in a stressful situation, but can furnish no response of value. It merely causes the patient symptoms which add to his problems. In these cases, symptomatic treatment is of great benefit, but often the underlying faulty pattern of response cannot be altered. Such a patient may literally be considered to be paying his way in life "through the nose."

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individual authorized by law to drive.

As we all know, driving is a complex task. As a matter of fact, the complete study of how complex it is has yet to be concluded. But, in brief—and this will be very brief, it consists of the sensing of numerous, sometimes fleeting factors; sorting them in order of significance, in very, very short periods of time; and making a decision which requires just as complex a motor response in order to control effectively the vehicle one is driving.

This takes place in terribly short moments. It has been estimated that every mile of driving on a highway entails twenty to sixty decisions. We do not think of it broken up that way, but we are constantly being bombarded with information through our senses. We are trying to use our brain, the cortical part as Dr. Krantz expressed to you, (1) to determine which of all the factors we sense are the important ones in making a judgment, and then, having made the judgment, (2) to make the proper maneuver to control the car effectively and prudently.

I shall try to separate some of the fact from the fancy and to dwell more on the logic and knowledge we have rather than on the lore that has come down through the years. I shall try to point out that the driver's task is modified by illness, by injury, by emotion and even by the treatment of these things, as indicated by Dr. Krantz just a few moments ago.

It is only in very recent years that significant statistical information has been obtained which permits the making of some definite recommendations by the medical profession.

The driving ability of an individual is definitely modified by any alterations in the physiological, the psychological, and the pathological conditions which influence that driver at any particular time.

These three P's are terribly important in the consideration of today's presentation: *Physiological, Pathological,* and *Psychological.*

In brief, and in lay terms, physiological factors are those having to do with the ability of the individual to function or to perform. There may not necessarily be a physical disease present when there is an alteration in a physiological factor.

Psychological factors are those which modify the ability of an individual to control his car because of his emotional reaction to a situation, to his environment, or to his illness.

Pathological factors are those due to disease or injury or other disability, either acute or chronic, which interfere with the individual's ability to sense, to sort, or to respond in such a prudent way as to be in control of his vehicle.

I shall touch on each of these three main categories, but will restrict myself to points which are supported by scientific or statistical evidence.

Probably no **physiological** factor has been studied more extensively over a longer period of time than fatigue. It has been well documented that with fatigue comes inattention, inability to sense all of the environmental changes, slowness in sorting out information received by the brain, and loss of active coordination in effecting the proper response.

As was just pointed out by Dr. Krantz, the use of amphetamines, or to a lesser degree some of the other stimulants, may not only be insufficient to overcome the deleterious effects of fatigue, but may also introduce some other undesirable effects from the drugs themselves, and such added effects may further impair the ability of one to drive.

A little less known, but equally well documented by now, is the effect of carbon monoxide concentration in the blood. It can impair attentiveness, perceptiveness, particularly at night, and may also interfere with motor coordination. Dizziness, lethargy, and sleepiness easily obtain with carbon monoxide elevation in the blood as they do with fatigue.

Most of us think of carbon monoxide concentration in the blood in relation to a poor exhaust system, a leaking of CO through the floor of a car, with this insidious, odorless, tasteless gas creeping in and overcoming the driver. Fortunately, this does not happen very often.

In addition to getting a higher concentration of carbon monoxide in the blood than is normally present through a leakage in the exhaust system, it is surprising how much carbon monoxide gets into your car while it is standing in traffic and your ventilator system is inhaling the exhaust fumes of the car right ahead of you. But even less well known is the fact that smoking, either by the driver or by occupants of a car when it has all the windows closed, has an even more significant deleterious effect.

It has been substantiated that the rapid smoking of three cigarettes in a closed car will alter the ability of the red part of the blood (hemoglobin) to combine with oxygen, to the same extent as being suddenly transported to an elevation of

8,000 feet. Hemoglobin, the oxygen-carrying part of the blood, is easily displaced by carbon monoxide, and it is much more difficult for the body to break up that combination of carbon monoxide and hemoglobin than it is to break it up oxygen alone combined with hemoglobin. So the effect of a certain amount of carbon monoxide is to cause what we call anoxia; and with anoxia come dimunition in visual acuity and impairment of judgment.

No one has any accurate figures about how significant such an association is in accident or collison causation, but the figures that have come out of California in the last few years indicate that several percent of fatal accidents revealed carbon monoxide concentration in the blood immediately after death. I might point out that taking blood-carbon monoxide is much more difficult than taking blood-alcohol. Carbon monoxide is very rapidly broken down when exposed to air; you have to take the blood sample under oil, so that no oxygen gets to it, and it must be done within a matter of minutes after the victim is brought in. It may contribute to a collision, but I can not give you exact figures.

Another physiological factor which may influence driving is age. We all hate to talk about age, but I am sure you have noticed how many people who get past sixty-five dislike driving at night, and there is a physiological explanation. As we get older our ability to see at basal level, what is called threshold vision, deteriorates. For every thirteen years we age we need twice the amount of illumination we did before. This explains why the older person may have to be restricted from driving at certain times of day, usually dawn or dusk when light intensity is poorest.

In addition to the loss of visual acuity that comes with age, at increments of thirteen, the recovery from glare diminishes or deteriorates as we get older. This is why many drivers who are quite competent during the day complain about the glare of oncoming headlights at night. Their seeing mechanism, to put it bluntly, does not respond, does not recover from that terrific glare which hits them, and they are momentarily blinded immediately after that glare has gone by, whereas a young person recovers much more quickly.

Another thing which many of us had not known before, but which has been documented recently, is that placing a piece of plate glass—and I am talking about plate glass because there is no distortion theoretically—between the outside and the driver of the car diminishes visual acuity both in young and in old. If that windshield made of plate glass is tinted, it affects visual acuity loss even more, particularly if the driver is in the older age group.

This ability to distinguish objects, to distinguish colors, to distinguish movement, is materially reduced with a tinted windshield over plain windshield, but even plain windshield causes some loss of visual acuity.

Many of you have heard about red-green color blindness and what it must do to the skill of the driving person, but statistically this has not been borne out. Red-green color blindness, which is mostly prevalent in males, and which is much more common than total color blindness, has no significant effect on driving ability as long as the red-green signals are in the same relative positions on the signal pole—in other words, as long as the red light is above the green light, and as long as the intensity of hue of these two prime colors is significantly different.

Another sense which we used to think was important in driving skill is hearing. But it has been shown, especially in modern society, that when we are all trying to screen out the extraneous sounds around us (and this goes on even when we drive), we depend more and more on our vision and less and less on our hearing. Hearing itself is therefore not too significant a physiological factor in the causation of a collision.

A good statistical summary was presented about two years ago by a jurist, I think in Colorado. When he investigated two hundred deaf drivers in the state, he found their driving records over a significant period of time were much superior to the driving records of the rest of the citizens of that state.

The next group of factors are the **psychological** ones or, in lay terms, the *emotional* factors, and they do play an important part in accident causation. It has been borne out by excellent studies made at Harvard Medical School, at Northwestern University, and in other centers throughout the world, that aside from the abuse of cars by obviously agitated, aggressive, or mentally disturbed patients for suicide or homicide—and automobiles have been used for those purposes—that "factors of attitude, personality, and adjustment

are of greater importance to safe driving than sensory defects, reaction times, or psychomotor skills."*

Among the examples usually given of such factors are those involving the individual who has had a fight with his wife just before he goes off to work in the morning; the one who is tense about taking a final examination later that day; and the individual who is depressed over a serious illness of someone close to him. The driving of such individuals leaves much to be desired when they are emotionally roiled by such factors.

Furthermore, it is well known now that the driver accentuates his usual emotional makeup or, as was stated a few years ago by Dr. McFarland, "One drives as one lives."

In all probability the causation of many, if not most, of the collisions which take place every day may well be associated with emotional or psychological factors causing loss of competency to drive. Until now, however, no effective or efficient screening test has been devised to identify such drivers and keep them off the road even for short periods of time. It is even more distressing that many chronically agitated or otherwise disturbed individuals, who have successions of accidents, cannot be effectively kept off the highways.

Until recently, chronic medical conditions were thought not to have a significant statistical association with traffic collisions, especially if they had been identified, treated and compensated for. In October, 1964, Dr. J. A. Waller of the California State Department of Health for the first time reported at the annual meeting of the American Association for Automotive Medicine that certain chronic medical conditions, at least in California, were associated with an increased incidence of traffic collisions.

He said, "Drivers with diabetes, epilepsy, cardiovascular disease, alcoholism and mental illness averaged twice as many accidents per million miles of driving, and 1.3 and 1.8 as many violations per hundred thousand miles as did drivers in a comparison group on an age-adjusted basis."

He added that the accident rates of drivers with medical conditions were further increased when they were over sixty years of age, had a poor attitude toward driving, or had a past history of an accident or violation related to the medical condition.

But Dr. Waller wisely warned that: "Since the present study is limited to drivers whose medical conditions were known to the California Department of Motor Vehicles, caution is urged in assuming a similar degree of driving handicap in unreported drivers with the same conditions."

In an even more recent review, dated November, 1965, Dr. Erma West, also of the California State Department of Health, investigated some eight hundred consecutive cases in a two-year period, in which death occurred within fifteen minutes of impact in an automobile collision. Dr. West recorded, "Drivers who died from natural causes just before their accidents constituted approximately 10% of the cases." This is the highest recorded validated report I have seen. Some of the literature from the Scandinavian countries, particularly Norway, is at the other extreme. Their reports indicate that very few collisions are due to medical conditions that precipitated death just before the collision. But I wonder whether they investigated and autopsied every driver as Dr. West's department did in California.

The 10% of the eight hundred were, for the most part, middle-aged or elderly men over forty; and most of them had suffered a coronary occlusion, which is a heart attack. A few had associated severe diabetes; and one had a massive blood clot of the lung which was due to hardening of the arteries.

Dr. West suggested that male drivers over forty years of age who are dead on arrival after an automobile collision, no matter how severely injured, should be autopsied to determine if a natural cause of death occurred prior to the accident. She further recommended that "Additional consideration should include placing heart disease on the list of conditions physicians must report to the State for purposes of determining fitness and requiring applicants for operator's licenses, and permits and renewal, to report heart disease along with the already reportable conditions on their application forms."

Acute medical conditions, due either to illness or to injury, may probably be more related to temporary driving impairment, and therefore accident causation, than the chronic illnesses mentioned before. It seems rather obvious that an application of a leg cast, or an arm splint, or a patch over an inflamed but otherwise normal eye, will certainly cause more impairment than the long-standing loss of a comparable member in a driver who had learned to compensate for the

*Ross A. McFarland, MD, Harvard School of Public Health.

loss. Certainly, the medications used in the treatment of these acute medical and surgical conditions may themselves increase the degree of driving impairment.

Physicians must be made to feel responsible for warning their patients about driving when such acute conditions are treated by appliances and restricted dressings, as well as by drugs.

It is because of the possible deleterious effects of medications that self-medicating patients must be advised that a cold remedy containing an antihistamine, purchased over the pharmacy counter, may be just as harmful to his driving ability as one prescribed by his physician. But the responsibility for his taking this medication and driving must rest with the driver, if he is involved in a collision. This is the same responsibility he assumes when he drinks alcoholic beverages and continues to drive.

I never heard counsel in a courtroom defending a client who had been involved in a collision associated with his drinking, state that the alcohol had impaired his driving. But I have heard counsel say that the reason his client was in a collision was that he took a medication. Now I think one is almost as foolish as the other, except that up until now there has not been sufficient publicity given to the ill effects of taking certain medications, either from a doctor or from the pharmacy, on driving ability.

Finally, I have been asked many times about the importance of a complete physical examination in discovering medical conditions which may impair driver competence. Surprisingly enough, in my considered judgment, it is not important at all. A very small percentage of physically disqualified drivers would be removed from the rolls if this were done; and, as was hinted before and pointed up, particularly in Pennsylvania's experiment, there are not enough physicians to spend as much time as is necessary for a decent examination on every driver applicant or every renewal candidate.

This is not to say that a physical examination for the purpose of making a clinical diagnosis is not important to the patient, but one must remember that very often it is only a symptom which impairs his driving and not necessarily a disease or illness. A physical examination would be ideal at the time of an applicant's original request, regardless of how old or how young he is at that time, but if it is impractical—and I feel it is in most states—then it should be done whenever there is an obvious physical or emotional impairment in the applicant.

Such original physical examinations would provide a base line against which renewal requests might be compared. At such times, the driver should be required to attest to his freedom from any defect or disability developing since that first physical examination. If he has developed such a condition or defect, the physical examination should be repeated and, to keep the renewal applicants honest, he should be made to appear before a representative of the Motor Vehicle Administrator in person, rather than to request his renewal by mail, such as is the case in this state now.

There are over 96 million licensed registered drivers in the United States. As I mentioned before, there are not enough physicians, even if they were to give up all types of practice, to do physicals on these.

In addition to the base line physical that I mentioned before, there are three occasions when a physical examination should be done.

It should be mandatory whenever a driver has been involved in multiple accidents within a short calendar period of time, without awaiting adjudication of fault. This is the experience that has led the State of Kentucky to have its law changed to read that three collisions within two years requires a physical examination of the involved driver.

Secondly, it should be required whenever a driver must be placed in the "assigned-risk pool" for insurance underwriting purposes, because commercial carriers have refused to assume the risk. This of course eliminates the driver who, because of youthfulness alone, is put in such a pool.

Thirdly, the physical examination must be done when the driver voluntarily suggests he "blacked out" or blames his mishap on a medical condition.

Drivers, their physicians, law enforcement personnel, motor vehicle administrators and their licensing staffs must be kept informed of the effects of physiological, psychological and pathological factors in determining driver limitation, especially as new information is developed. If physicians are protected by law whenever they are required to report medical information about their patients to a State Motor Vehicle Administrator, or better yet, to his Medical Advisory Board, this one aspect of driver limitation and its control will improve.

Legal Problems Involved in the Development of Legislation

J. DUDLEY DIGGES
Chief Judge, Seventh Judicial Circuit, State of Maryland

The legal profession is vitally interested in the problem that you are undertaking to discuss here today. We are interested in it for several reasons, among them a selfish one: I am now serving as chairman of a committee composed of the chief judges of the State and concerning itself with the backlog of cases that have accumulated in Maryland.

As of September 1, there are some 74,000 cases pending in this state. Of those cases that are triable, a good 85% are concerned with motor vehicle accidents, and the damages and injuries that have occurred as a result of them. When you figure that a judge can try only approximately 125 cases per year, and there are only 70 judges in the state, you can see the problem that that in itself causes.

I may say that Maryland is extremely fortunate in comparison with New York City, which is some five years behind in taking care of the trial of cases, with great financial hardships not only for the victims, but indeed for the medical doctors who have performed services, who should be paid, and who should not have to wait for some five years to be paid.

You can see we are going to have a breakdown in the judicial processes that can be serious, because really this is the backbone of operation of a civilized society. And so I readily accepted the invitation to appear here today. It is important that we do everything both in and out of the medical field, both in and out of the legal field, and indeed both in and out of all fields, to attempt to solve this problem, which is becoming such a menace all over America that it would not surprise me if someone suggested the only answer to it was to outlaw the automobile itself. That might seem drastic, but nevertheless we cannot go on in the manner in which we have been going. The legal profession is looking for other methods to settle the disputes so that the general machinery of the courts as we now know it can continue to function and not be clogged.

But we all must recognize that whatever solution is attempted must come within the framework of what we have learned in this country to call constitutional privileges, constitutional guarantees, which cannot be cast aside, no matter what the reason. The reason I say that is simply because the American people will not stand for anything short of these guarantees because they are so far-reaching. It is within that framework that I want to discuss today, not of course from the medical point of view, but from the legal point of view, the absolute minimum with which we must concern ourselves.

First of all, I must say that the answer to what meets the constitutional requirements depends largely upon developments in the medical field. That is not only true in this field; it is true in many others.

Within the last six months I presided over a case involving the constitutionality of Patuxent Institution. From a constitutional point of view, the whole case turned on the question of whether or not the medical profession had progressed in its discoveries and development to such an extent that there was reasonable unanimity among physicians as to what can be accomplished in an institution like Patuxent.

I spent a whole week—some 8,000 pages of testimony—dealing with this question. The testimony was largely from doctors, such people as Dr. Karl Menninger and other experts in this field, so that it could be determined whether you medical folk had reached the state where the law can be based on sound principles.

The number one requirement here is that the statistics you gather, which show, for example, that a certain percentage of alcohol in the blood destroys the effectiveness of a driver, be a reasonable basis for a decision. This can be determined

only by you in the medical field and by those associated with you.

As I mentioned at the outset, from a legal point of view the problem goes back to the concept that the driving of a motor vehicle is a privilege and not a right. Just how long that concept will continue in effect I do not know, but when it changes, and it is determined that driving is a right rather than a privilege, then all of the decisions of the law that have been made or suggested will go down the drain along with the present concept.

A change may come as we in this country become more and more dependent upon the automobile for our livelihoods, for our use almost every time we turn around. It may be that one of these days it can be so wound up in our daily lives that the operation of a motor vehicle will be deemed a right, guaranteed by the various provisions of the constitution, and not a privilege.

Meanwhile in today's law we deal with this as a privilege, a privilege which is granted to an individual, but which may be withdrawn, provided of course that the reason for withdrawal meets other constitutional tests, and provided that all in the same category are treated alike.

It is within this framework that some of the proposed laws are referred to as the "implied consent" laws. They are now on the books in a number of states, among them New York, Idaho, Kansas, Utah, North Dakota, South Dakota and Vermont.

The concept of driving a car as a privilege was adopted by the National Conference of Commissioners on Uniform State Laws in 1957, and approved by the American Bar Association in the same year.

Briefly, the law provides that anyone who applies for an operator's permit and who uses that permit to operate on the highways of the state, impliedly consents to a test to determine whether or not he was driving under the influence of alcohol and to the withdrawing of blood, providing it is done by a doctor, a qualified technician, chemist, registered nurse or someone in an allied field.

If the person does not agree—and he has a complete option to agree or not to agree—his operator's license is automatically withdrawn.

If the person is incapable of consenting or agreeing because of death or some other reason, then the doctor has the absolute right, at the direction of the proper authorities, to proceed to draw the blood in order to make the test.

The law then specifies—and this must be based on medical conclusion, with reasonable unanimity among your profession—what degree of alcohol, in what category. Of course the law would have to be changed if you made discoveries which changed your conclusions.

The test that is set forth is for five hundredths of one per cent of alcohol in the blood, by weight. At that point the person is still deemed accountable. Then it goes on up until such time as there is a prima facie presumption that he is too intoxicated to operate a motor vehicle.

Without going into the advisability or the nonadvisability of the passage of that law—and most people who have made studies of it believe it is a very desirable law—there are many other laws that could be considered.

For example, there could be a law based not on *implied* consent, but on *affirmed* consent and requiring the individual to sign the consent in order to get a license. That has its drawbacks, however, because out-of-state drivers in a state with such a law may not be subject to it in their home states and implied consent would be applicable to them.

There is one case that I want to call to your particular attention. This is a very recent case that came as a surprise to me, in view of the various trends of the Supreme Court. It was decided just last June—June 20, 1966. I think it has a great bearing on this problem.

The case was one that arose in California (Schmerber vs State of California). The defendant was initially convicted in the Los Angeles Municipal Court for driving a motor vehicle while under the influence of intoxicating liquor. After the defendant's arrest, while he was in a hospital receiving treatment for the injuries suffered in the automobile accident, a blood sample was withdrawn by a physician at the direction of the police officer, acting without a search warrant, despite the defendant's refusal on the advice of his counsel, who was present, to consent to the blood test.

The report of the chemical analysis of the test, indicating intoxication, was admitted in evidence at the trial over the defendant's objection that the compulsory blood test, and the admission of the evidence thereof, violated his right to due process of law under the Fourteenth Amendment, and his

privilege against self-incrimination under the Fifth Amendment, his right to counsel under the Sixth Amendment, and his right against unreasonable searches and seizures under the Fourth Amendment, insofar as such rights were secured against the states by the Fourteenth Amendment. So the whole gamut of constitutional objections was raised in this case.

Amazingly enough, the Supreme Court upheld the decisions of the California courts five to four. I say "amazingly enough" because the tendency had been five to four the other way up until this case. Justices Warren, Black, Douglas and Fortas dissented very vigorously, but the majority of the Court answered all of the constitutional objections, and briefly I will tell you the basis upon which they agreed.

They decided that the defendant was not deprived of due process of law because there the withdrawal was made by a physician in a simple, medically acceptable manner in a hospital environment. They put it right back in the laps of the medical profession to make a determination as to whether he was being subjected to anything that did not represent justice and fair play.

If it is a medically accepted method, then apparently that would meet the argument that there was not due process of law, as enunciated by the Supreme Court in this case.

The more troublesome problem comes under the Fifth Amendment of the Constitution which guarantees any defendant the privilege against self-incrimination. When this defendant submitted to the taking of his blood, it was argued that he was thus required to give evidence against himself, which of course was made unlawful long ago when the Magna Carta was extracted from King John of England.

The Court denied that contention in these words: "It could not be denied that in requiring petitioner to submit to the withdrawal and chemical analysis of his blood, the state compelled him to submit to an attempt to discover evidence that might be used to prosecute him for a criminal offense. He submitted only after the police officer rejected his objection and directed the physician to proceed."

That language is of peculiar importance to doctors, I would think, because the proceeding was at the direction of the police officer and over the objection of the defendant.

The Court said: "The officer's direction to the physician to administer the test over petitioner's objection constituted compulsion for the purposes of the privilege. The critical question, then, is whether petitioner was thus compelled 'to be a witness against himself'."

The Court answered that by saying: "History and a long line of authorities in lower courts have consistently limited its protection to situations in which the state seeks to submerge those values for obtaining the evidence against an accused through 'the cruel, simple expedient of compelling it from his own mouth'." Implicit, no doubt, was that this would apply to all things. The Court laid stress on the fact that the drawing of a little blood was of a very minor nature and akin to compelling a man to submit to a fingerprint test. It intimated that pumping the stomach, or something of that nature, would not be a simple thing such as we are dealing with here.

"In the present case, however, no such problem of application is presented. Not even a shadow of testimonial compulsion upon, or enforced communication by, the accused was involved either in the extraction or in the cehmical analysis. Petitioner's testimonial capacities were in no way implicated; indeed, his participation, except as a donor, was irrelevant to the results of the test, which depend on chemical analysis and on that alone."

The next question was the one related to the Sixth Amendment, his right to counsel. The Court quickly disposed of that by saying you cannot argue that he was deprived of counsel just because counsel was not permitted to have him do what he wanted to do; that if he couldn't claim the privilege himself, he couldn't do it by a law; and if a lawyer advised him not to submit to it, he was erroneously advised.

The next question was under the search and seizure procedure of the Fourth Amendment. The Constitution there guarantees everyone's freedom from having anything seized from him—papers, house search, person—without a warrant.

You will note the case was without a warrant and, as a matter of fact, the man had not been charged, and the officer was merely determining whether there was sufficient evidence to charge him.

The majority of the Court rejected that proposition and said: "The interests in human dignity and privacy which the Fourth Amendment protects forbid any such intrusions on the mere chance that desired evidence might be obtained. In

the absence of a clear indication that in fact such evidence will be found, these fundamental human interests require lay officers to suffer the risk that such evidence may disappear unless there is an immediate search."

But, they said, when there is probable cause to believe that the person may be guilty of the violation of this law, that in itself was justification for the officer requesting the examination over objection, and that if there exists probable cause—and they gave as examples the smelling of alcohol on his breath, the way the vehicle was being operated, the result of the accident itself—those things in themselves can be taken into account; that if there was probable cause to believe he had too much to drink, that was justification for the arrest, and when there is an arrest, anything that may be found on him and used in this respect could be used.

"The officer in the present case, however, might reasonably have believed that he was confronted with an emergency"—and the Court laid great stress on the fact that the medical profession had concluded that the longer you wait after an accident to make this test, the more inaccurate it may be—as reflecting on the true situation at the time. Relying on that, they said, he was justified in acting quickly.

I mention this case particularly because for the first time there is a good indication from the Supreme Court that maybe the machinery exists now for doing a whole lot that we did not think could be done. It is not merely a question then of dealing with a driver's license; even in a criminal case (which this was) where the man's liberty might depend upon the result, these constitutional guarantees do not prohibit the taking of blood as it was taken in this case. And, as far as I know, it is the generally accepted way and not peculiar to the case in question.

But it is a serious problem. I am not suggesting that we do not need further legislation. I am suggesting that maybe the time has come to utilize all facilities. The reason is simply this: fundamental in the American Constitution is the right to trial by a jury. Maybe you would and maybe you would not be amazed at the reluctance of juries to convict people of driving under the influence of liquor.

I admit times have changed, but I remember the first year I was out of law school. I tried before one jury 15 driving-under-the-influence-of-liquor cases, and was successful in having 15 of them found not guilty. This was no great feat on my part; juries would not convict anyone. They are reluctant to do it today, simply because they figure there is a great possibility that "I could be sitting in that defendant's chair."

Therefore I think it is important that we deal with the criminal problem (we have the machinery now, apparently, to do it with the constitutional limitation) and that we also go one step further and consider the desirability of abolishing most motor vehicle laws as being violations of the criminal laws.

I admit that sounds rather drastic, but let me explain. Among my duties, I sit in juvenile court, and I have young people before me who are charged with all kinds of things—not necessarily motor vehicle charges. As a matter of fact very few motor vehicle cases come to youth court. I can tell a boy I am going to send him to training school for six months and get no reaction, but as soon as I tell him I will take his driver's license, and give it to the State's Attorney to be returned to the Commissioner of Motor Vehicles, an eighteen-year-old boy will start to cry.

So I think the way to deal with this problem is to withdraw the individual's privileges when the law has been abused. There should be a simple process to determine that *without* submitting a case to a jury or anyone else.

I realize there have to be certain fundamental safeguards, but we have them now in various boards. As a matter of fact, the Commissioner of Motor Vehicles passes on the question of whether or not the license is to be withdrawn after a conviction. I do not think it should be necessary to impose conviction there. If he abuses this privilege, withdraw the privilege and, similarly, if he abuses privileges of hunting because he shoots too many ducks, withdraw the privilege until he demonstrates a sense of responsibility in that area.

I say that the thing is getting beyond the capability of the courts to deal with in its many facets. It has other ramifications. I agree that people's jobs are at stake, feeding families is at stake—so are welfare departments, all agencies. As a matter of fact, modern life itself is concerned with this whole problem, but I don't think it is insoluble. I think the constitutional limitations do not prohibit a sane approach to the problem which can rectify the whole situation.

New from Du Pont

Symmetrel®

(Amantadine HCl)

The first oral chemical virostat for the prevention of influenza A_2



Influenza virus
Protein shell enclosing the core of nucleic acid (RNA)—artist's representation

The incidence of influenza A_2. In this country, where influenza is one of the leading causes of morbidity, influenza A_2 (Asian) continues to be a serious medical problem. In 1957 influenza A_2 was responsible for approximately 40,000 excess deaths in a three-month period. Since that year the most prevalent influenza virus has been A_2 (Asian).

What is Symmetrel®? "Symmetrel" (amantadine HCl) is a new synthetic chemical which acts as a molecular barrier to virus penetration. It provides for the first time specific oral medication for the prevention of respiratory infections caused by influenza A_2 (Asian) viruses—an entirely new approach in preventive medicine.

For prescribing information, see last page of this presentation

What Symmetrel® (amantadine HCl) means to you

...the first and only oral chemical agent to prevent influenza A_2 (Asian).

...not a vaccine or antibiotic, but a new synthetic chemical unrelated to any other chemotherapeutic agent.

...unique mode of action: prevents virus penetration of the host cell without affecting vital cell functions.

...specifically active against all influenza A_2 viruses tested to date.

...not indicated for the prevention of influenzal or respiratory illness other than influenza A_2 or for the treatment of established disease.

...does not interfere with normal antibody response; acts in concert with pre-existing antibody.

What Symmetrel® means to your patient

...possible immediate influenza A_2 protection when taken following suspected contact.

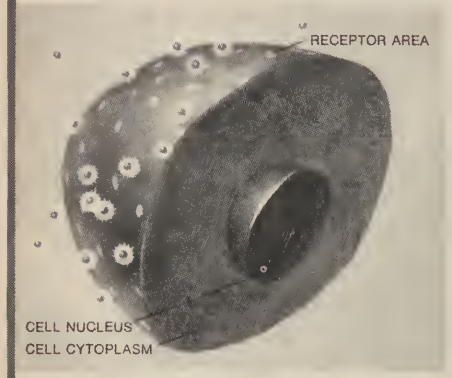
...may be particularly useful during outbreaks or epidemics and for high-risk patients in whom the occurrence of influenza A_2 is especially hazardous.

...a high degree of safety in clinical use.

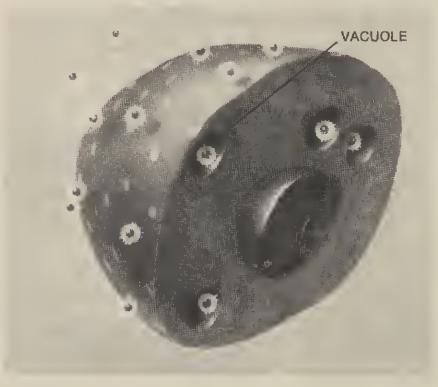
...simple once daily or b.i.d. dosage.

The mode of action of Symmetrel®

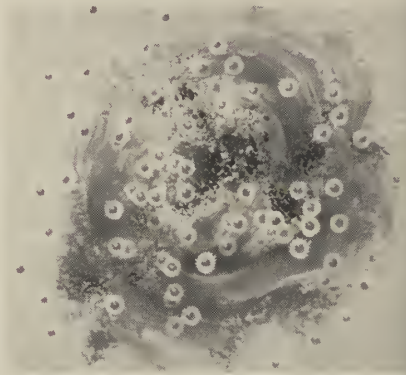
How the influenza virus invades and destroys the untreated cell



1 Viruses outside the cell attach themselves to specific cell receptor areas

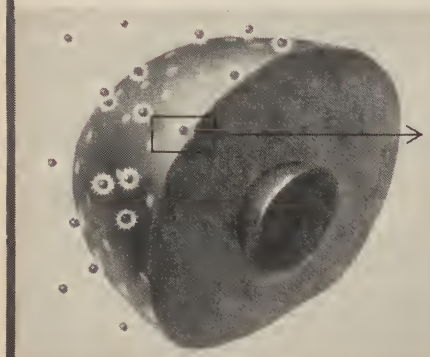


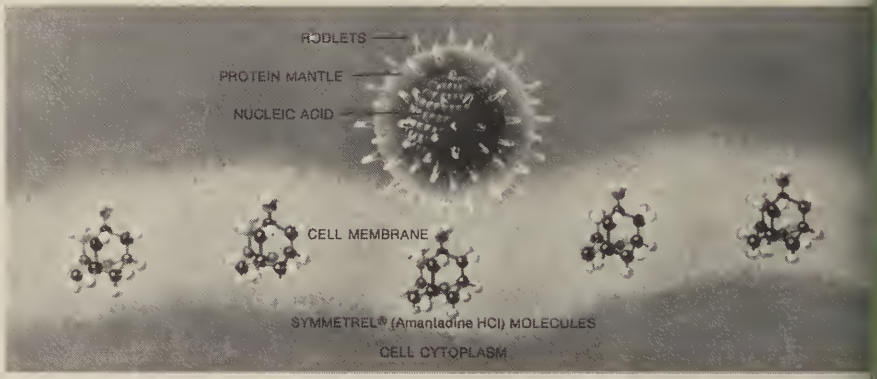
2 The virus is incorporated into a vacuole within the cell. From this vacuole the virus nucleic acid passes into the cell cytoplasm



3 The virus nucleic acid then directs the cell to produce both new virus nucleic acid and virus protein coat material which aggregate to form new virus particles. This process leads to the release of new virus particles and eventual destruction of the cell

How Symmetrel® (Amantadine HCl) prevents virus invasion[1]





Our current knowledge leads us to believe "Symmetrel" acts as a molecular barrier to influenza virus penetration. Shown here in a greatly enlarged section, "Symmetrel"—located at the cellular membrane—effectively prevents (blocks) virus penetration. Thus, "Symmetrel" does not directly destroy the virus particle but acting as a virostat prevents the cycle of virus penetration, virus replication, and cell destruction that is characteristic of virus invasion of animal cells (tissue). *Artist's conception based on current scientific knowledge.*

1. "Mode of Action of the Antiviral Activity of Amantadine in Tissue Culture", Hoffmann, C. E.; Neumayer, E. M.; Half, R. F.; and Goldsby, R. A., Journal of Bacteriology *90*,623 (1965).

Safety of Symmetrel® Confirmed. When used as indicated, is generally well tolerated. No kidney, liver, bone marrow, or hematological disturbances have been observed.

Prescribing Information

Indications: "Symmetrel" is indicated for the prevention (prophylaxis) of influenza A_2 in persons of all age groups. Early use is recommended, preferably before or as soon as possible after actual or suspected contact with individuals suffering from influenza A_2. "Symmetrel" should especially be considered for high influenza-risk patient groups such as those suffering from chronic debilitating diseases and elderly persons.

Contraindications: Not indicated for the prevention of influenzal or respiratory illness other than influenza A_2 or for the treatment of established disease.

Warnings: Administration to patients with central nervous system disease, particularly geriatric patients with cerebral arteriosclerosis, and patients with a history of epilepsy or other "seizures," requires strict observation for possible untoward effects (see Adverse Reactions). Patients taking psychopharmacologic drugs, central nervous system stimulants, or alcoholic beverages should be observed for possible evidence of intolerance. Those patients who experience central nervous system effects or blurring of vision should be cautioned against driving or working in situations where alertness is important.

No teratogenic effects have been seen in reproductive studies in rats and rabbits. Studies in pregnant women have, however, not been done and use of this drug in women of childbearing age should be undertaken only after weighing the possible risks to the fetus against benefit to the pregnant patient. It should not be administered to nursing mothers since it is not known whether the drug is secreted in the milk.

Precautions: Ineffective against bacterial infections. Patients should be observed for idiosyncratic reactions as with all new drugs. Geriatric patients with pre-existing serious medical illnesses with mental or physical deterioration should be followed carefully medically while taking "Symmetrel." (See Adverse Reactions.)

Adverse Reactions: With higher than indicated doses manifestations of central nervous system effects such as nervousness, insomnia, dizziness, lightheadedness, drunken feeling, slurred speech, ataxia, inability to concentrate and some psychic reactions including depression and feelings of detachment were seen. Occasional blurred vision was reported at higher doses. Some of the milder and less pronounced symptoms above have been reported in a small number of patients taking the recommended dosage of 200 mg per day. Those were mostly transient and disappeared with continued administration of the drug. Some geriatric patients developed paranoid or hallucinatory behavior and became unmanageable while taking 200 mg daily. Medically unselected seriously deteriorated geriatric patients showed poor clinical tolerance after several weeks of daily dosing with 200 mg per day. One elderly patient with a history of prior cerebrovascular accident developed visual hallucinations and grand-mal convulsions while on drug at 800 mg per day. Some cases of dry mouth, gastrointestinal upset and skin rash and rarely, tremors, anorexia, pollakiuria, and nocturia have been also reported.

Safety: When used as indicated, is generally well tolerated. No kidney, liver, bone marrow, or hematological disturbances have been observed.

Dosage: *Adults:* Two 100 mg capsules (or 4 teaspoonfuls of syrup) as a single daily dose or the daily dose may be divided into one capsule of 100 mg (or 2 teaspoonfuls of syrup) twice a day.

Children: 1 yr.—9 yrs. of age: Calculate total daily dose on the basis of 2 mg to 4 mg per pound of body weight per day (but not to exceed 150 mg per day). Daily dose, given as the syrup, should be given in 2 or 3 equal portions.

9 yrs.—12 yrs. of age: Total daily dose 200 mg given as one capsule of 100 mg (or 2 teaspoonfuls of syrup) twice a day.

How Supplied: *Capsules:* Bottles of 100. Each red, gelatin capsule contains 100 mg amantadine HCl.
Syrup: Bottles of 1 pint. Each 5 ml (1 teaspoonful) contains 50 mg amantadine HCl.

DUPONT

Symmetrel®

(Amantadine HCl)

A molecular barrier to virus penetration

arrest diarrhea

in • gastroenteritis • acute infections



LOMOTIL®

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . . 0.025 mg.

Effectiveness: Lomotil possesses a unique degree of effectiveness in both acute and chronic diarrhea.

Convenience: Lomotil is supplied as small, easily carried, easily swallowed tablets and as a pleasant, fruit-flavored liquid.

Versatility: The therapeutic efficiency, safety and convenience of Lomotil may be used to advantage alone or as adjunctive therapy in diarrhea associated with:

- **Ulcerative colitis**
- **Acute infections**
- **Irritable bowel**
- **Regional enteritis**
- **Drug therapy**
- **Food Poisoning**
- **Functional hypermotility**
- **Malabsorption syndrome**
- **Ileostomy**
- **Gastroenteritis and colitis**

Dosage: For correct therapeutic effect—Rx correct therapeutic dosage. The recommended initial daily dosages, given in divided doses, until diarrhea is controlled, are:

Children: Age	Total Daily Lomotil Dosage	Lomotil Liquid Dosage (Each teaspoonful [4 cc.] contains 2 mg. of diphenoxylate HCl)
3-6 months	3 mg.	½ tsp. 3 times daily
6-12 months	4 mg.	½ tsp. 4 times daily
1-2 years	5 mg.	½ tsp. 5 times daily
2-5 years	6 mg.	1 tsp. 3 times daily
5-8 years	8 mg.	1 tsp. 4 times daily
8-12 years	10 mg.	1 tsp. 5 times daily

Adults: 20 mg. (2 tsp. 5 times daily or 2 tablets 4 times daily) Based on 4 cc. per teaspoonful. Maintenance dosage may be as low as one-fourth the initial daily dose.

Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is a Federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be kept out of reach of children since accidental overdosage may cause severe respiratory depression. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.



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DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

s effective b.i.d.



It's made for b.i.d.

ective in a wide range of everyday infections — respira-
y, urinary tract and others — in the young and aged —
e acutely or chronically ill — when the offending organ-
ns are tetracycline-sensitive.

ntraindication — History of hypersensitivity to demethyl-
lortetracycline.

arning — In renal impairment, usual doses may lead to
cessive systemic accumulation and liver toxicity. Under
ch conditions, lower than usual doses are indicated
d, if therapy is prolonged, serum level determinations
ay be advisable. A photodynamic reaction to natural or
ificial sunlight has been observed. Small amounts of
ug and short exposure may produce an exaggerated
nburn reaction which may range from erythema to
vere skin manifestations. In a smaller proportion, pho-
allergic reactions have been reported. Patients should
oid direct exposure to sunlight and discontinue drug at
e first evidence of skin discomfort.

ecautions and Side Effects — Overgrowth of nonsuscep-
le organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg; *Tablets:* film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

DERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

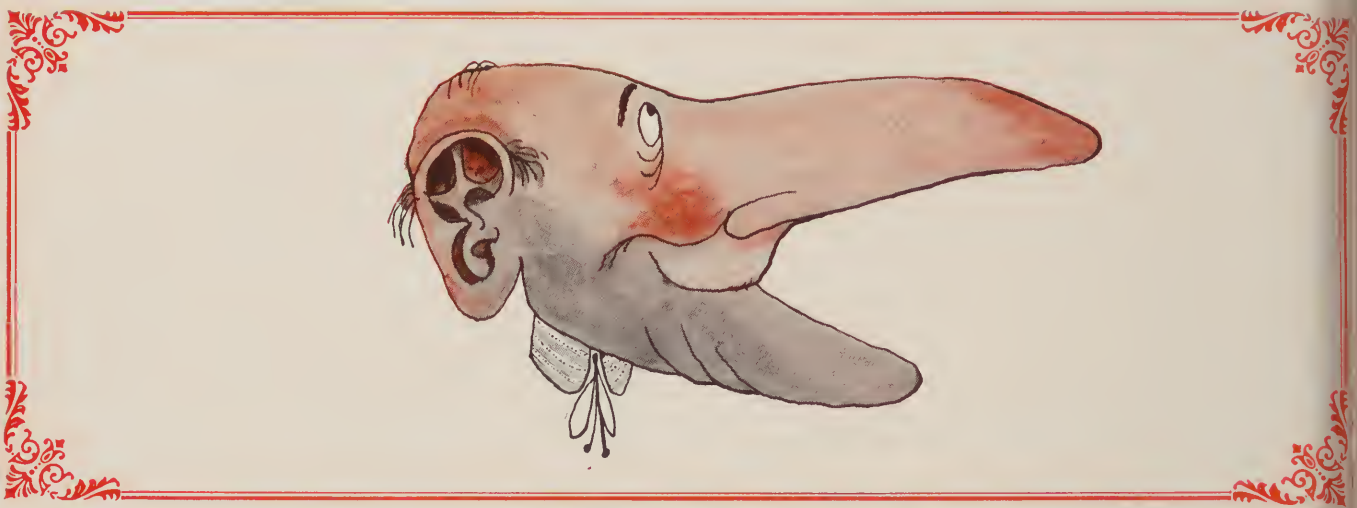
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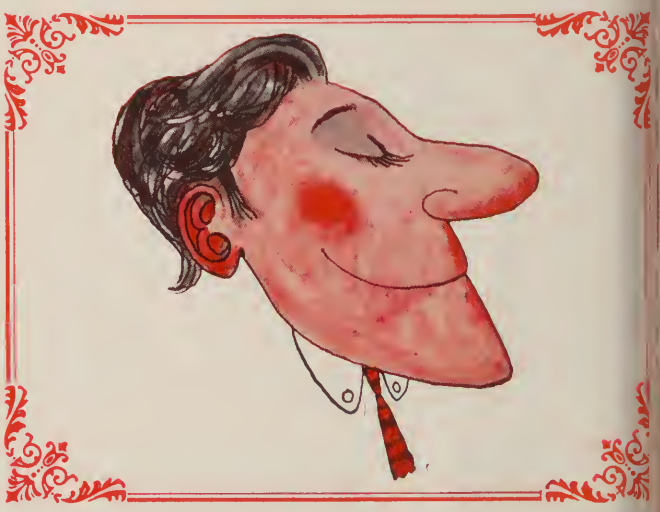
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POSTGASTRECTOMY SYNDROMES

WALTER F. BALLINGER, II, MD
Associate Professor of Surgery
The Johns Hopkins University School of Medicine

Postgastrectomy syndromes are identified and described. Vagotomy and pyloroplasty are advanced as preferable to subtotal gastrectomy with a gastrojejunostomy except in a case of malignant disease, since they comprise a conservative alternative which is much less likely to produce such results. Medical treatment and surgical correction of the more serious postgastrectomy syndromes are discussed.

The selection, by the Program Committee of the Medical and Chirurgical Faculty of the State of Maryland, of representatives of the Departments of Surgery of both of Baltimore's medical schools to deliver the first annual Amos R. Koontz Memorial Lecture would have pleased Dr. Koontz greatly. He not only gave much of his time to organized medicine through this Faculty, but also was intimately involved with the problems of teaching and of research. It is thus especially appropriate and gratifying to those of us engaged in academic surgery that my distinguished colleague, Dr. Robert Buxton, of the University of Maryland, and I, of Johns Hopkins University, were asked by your Program Committee to represent both schools of medicine in Maryland as Koontz Lecturers at the annual meeting of Maryland's Medical and Chirurgical Faculty.

Dr. Koontz spent many years in a noble field of surgery, that of reconstruction, repairing the hernial defects of nature and those created by surgeons.

It is a form of reconstruction about which I will speak here—repair of the altered physiology created by the surgeon in attempts to control the complications of peptic ulcer disease. Although gastrectomy has been practiced by surgeons for over 80 years, at times timidly and at times aggressively, it has only been in recent years that surgeons have developed a real awareness of, and concern for, their results. Internists and family practitioners can appreciate this statement since these physicians have followed postgastrectomy patients far more assiduously than surgeons have in past years.

Increasing awareness of the problem is a reflection of long overdue recognition of a splendid conservative alternative to removal of the stomach. This alternative procedure takes advantage of the fact that reduction (1) of the control of the brain over rates of gastric secretion of hydrogen ion by vagotomy, and (2) of gastric holdup of ingested alkaline food by pyloroplasty, permits an ulcer to heal, yet allows that complicated organ, the stomach, to remain otherwise undisturbed.

Subtotal gastrectomy, that is, removal of 50% to 75% of the distal stomach, with the performance of a surgical union between the proximal remaining gastric pouch and the jejunum,

Amos R. Koontz, MD, Memorial Fund Lecture presented April 28 at the 168th Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland.

remains the commonest surgical procedure for control of benign peptic ulceration today. Yet it is a field of controversy and in any such controversial area there are advantages and disadvantages in taking sides.

Nevertheless, I will side immediately with the gastric conservationists, opposed to removing an organ unnecessarily, dedicated to gastric preservation using vagotomy and pyloroplasty, and concerned about the number of patients unable to gain weight with various degrees of malabsorption after the standard subtotal gastrectomy and Billroth II gastrojejunostomy.

Variation in response to gastrectomy is a complicated subject in itself and it is only fair to state that this procedure has resulted in hundreds of thousands of relatively satisfied patients and only tens of thousands of dissatisfied ones.

Degrees of success are dependent upon the extent of resection, the preoperative weight of the patient, psychic factors, technical problems of anastomosis, etc. Nevertheless, it seems that there are fundamental factors in the development of the postgastrectomy syndromes. This is a plural term and it has only recently been pluralized. It has long been recognized that inadequate intake, bloating, cramping, diarrhea, and weight loss may follow gastrectomy, but specific symptom complexes have now become linked with anatomic and biochemical explanations. There is also a group of postgastrectomy syndromes caused by the operation and manifested in various ways. I shall attempt to persuade you that they can be relieved or cured sufficiently by an operation devised to restore as nearly normal anatomy and physiology as possible.

Several unphysiologic events, which are greatly significant to the economy of the patient, are permitted to take place by the performance of gastrectomy. One of the factors in the development of the postgastrectomy syndromes is a small stomach reservoir. Undigested hypertonic food is permitted to pass rapidly into the unprotected jejunum. It bypasses an afferent loop of duodenum where pancreatic and biliary secretions pour into the proximal portions to mix with gastric contents—but do not reach them until 12, 14 or 18 inches lower down in the gastro-intestinal tract. Finally, the absence of the normal antropyloroduodenal neuromuscular mechanism to hold up gastric emptying has a strong role in the development of the postgastrectomy syndromes.

There have been many classifications of the various syndromes—acute, chronic, etc. I prefer the division into mechanical, metabolic, and combined types, although most of the postgastrectomy syndromes are "combined" and therefore complex. The mechanical are the simplest and include internal hernia, intussusception of the jejunum into the stomach, etc. An example of a metabolic syndrome is the dumping syndrome, suffered by many patients after significant degrees of surgical resection of the stomach. The combined syndromes are exemplified by the afferent loop syndrome, which involves partial obstruction, stasis of duodenal contents and, in many cases, overgrowth of bacteria. The latter condition is frequently associated with an interesting, yet poorly understood malabsorption.

Most, if not all, patients who have severe manifestations of postgastrectomy syndromes develop psychiatric problems. Those of us who have had contact with patients who suffer severely and become "gastric cripples," realize the tremendous overlap of the psyche in this situation.

Finally, there is an intensification of various latent metabolic defects—of which lactase deficiency is an interesting example. In this condition patients who had mild or no milk intolerance before gastrectomy, develop severe intolerance to milk or milk products after removal of the stomach and ablation of the pylorus.

I will describe briefly some of the major postgastrectomy syndromes which are recognized as clear entities. My comments will be confined primarily to the early dumping syndrome rather than to the late hypoglycemic manifestations of dumping. The small stomach syndrome will be commented upon briefly, as well as afferent loop problems, problems of vagotomy and, finally, anemia, malabsorption and malnutrition.

Small Stomach Syndrome

The small stomach syndrome is obvious in its descriptive terminology. It varies with the extent of gastrectomy. Assuming that in most gastrectomies approximately 60% of the stomach is removed, with only 40% of the upper portion of the stomach left intact, one can realize that a major portion of the reservoir function of the stomach

and a large part of the mixing function of the stomach have been impaired.

The patient experiences an early sensation of fullness after ingestion of a small amount of food. This is accompanied by considerable epigastric discomfort which may proceed to severe pain. Nausea and vomiting are features of this effect, which occurs during the ingestion of food, not afterward. The patient responds quite dramatically by reducing his intake; weight loss and malnutrition follow. The malnutrition one sees after gastrectomy is probably due in large part to inadequate intake rather than to problems, complex as they are, of malabsorption.

The patient usually learns to treat his own small stomach syndrome but the best form of treatment is obviously prevention—avoidance of extensive gastric resection except when absolutely necessary. Frequent small feedings are resorted to by the patient and advised by the physician. Change in dietary intake, with a decrease in the amount of fat, will help in some cases. Finally, a segment of intestine—usually jejunum—can be interposed between the small gastric remnant and the duodenum, primarily to enlarge the stomach pouch and, secondarily, to restore more normal gastroenteric continuity from stomach to duodenum.

Malabsorption

Postgastrectomy malabsorption, a combined metabolic and mechanical defect, is caused by the reduced gastric reservoir followed by insufficient gastric digestion, poor mixing and rapid emptying; defective stimulation, because of the small gastric reservoir of the pancreas and gallbladder; and the absence of the normal antropyloroduodenal emptying mechanisms. Incoordination of gastric emptying causes incoordinate secretion of pancreatic and biliary substances into the duodenum. This is further complicated by the very rapid passage of contents to the intestine.

This complex subject is poorly understood. Nonspecific blunting and thickening of the jejunal mucosa occur far below the gastrojejunostomy. Although for many years it has been suggested that such mucosal changes occur, the more sophisticated techniques of biopsy now available indicate that they may be more common than was once supposed.

Dumping Syndrome

It should be noted that there are two major components in the disabling dumping syndrome: the intestinal and the vasomotor. The intestinal components are well-known: fullness, cramping, vomiting, explosive diarrhea, all occurring during the ingestion of foods or very shortly thereafter. These are then accompanied by weakness, dizziness, increased sweating, and tachycardia, of which the patient is aware. Increased peripheral blood flow has been observed in association with dumping.

In the 1920's, the rather obvious observation was made that food was literally "dumped" too early and too rapidly into the upper jejunum. Hyperglycemia was the first manifestation of the dumping syndrome that was actually measured. It then became clear that the elevation of blood sugar did not exactly parallel the development of symptoms. It was postulated that removal of one of the stomach's very important and little appreciated functions—that of an osmotic shield—could play a part in the dumping syndrome since the gastric mucosa does not permit rapid transfer of plasma from the blood into the stomach as it does in the jejunum. This loss of protective effect may account for the dumping. This, however, did not explain the entire syndrome; and approximately 10 or 15 years ago the very precipitous drop in plasma volume following the ingestion of a hypertonic carbohydrate substance into the jejunum was first described. This can be duplicated in normal individuals by passing the substance through a tube into the jejunum.

It was demonstrated by Hinshaw and associates in California, however, that the blood volume decrease did not exactly parallel the onset of symptoms. In an attempt to correlate redistribution of blood flow with symptoms, they put a plethysmograph on the tips of the fingers of various subjects. A rise in peripheral blood flow associated with dumping was discovered. This has been supported by many investigators, as is also true of renal plasma flow.

A marked redistribution of blood flow to the periphery in dumping became apparent—a totally unexpected finding. Other investigators have recently noted that the mucosa of the proximal gut contains large quantities of serotonin and, in asso-

ciation with dumping, have measured volumes of serotonin in the portal vein in experimental animals. Intravenous injections of serotonin into humans have reproduced the dumping syndrome. This of course explains the many attempts by clinical investigators to abolish the dumping syndrome through the use of serotonin antagonists, and it has been shown that rather large doses of serotonin antagonist will control many of the manifestations of dumping.

Thus the dumping syndrome, in its milder or moderate forms, can be treated medically with means—for instance, reduction of the osmolarity ease. Gastric emptying can be delayed by other of the gastric content by control of dietary intake. Some patients do not respond to these forms of therapy, however, and surgical reconstruction is preferable. It is well-known that patients who have a Billroth I or gastroduodenal anastomosis following gastrectomy have a lower incidence of dumping than those with an anastomosis between the jejunum and the cut end of the distal stomach or the proximal stomach.

Afferent Loop Syndrome

One of the more interesting postgastrectomy syndromes is the afferent loop syndrome. This is caused by the presence of a long loop between the closed end of the duodenum and the gastrojejunal anastomosis. This long loop (which in unusual examples may be as long as 36 inches) can herniate, thus causing a chronic obstruction. The type of obstruction which commonly develops with a long afferent loop results from the formation of scars at the site of the gastrojejunal anastomosis.

The afferent loop syndrome is characterized by severe crampy pain, by nausea during the ingestion of food or very shortly afterward, and by projectile vomiting, which often immediately relieves the pain. Weight loss results because the patients are simply afraid to eat. Many investigators have demonstrated blind loop complications due to stasis of duodenal contacts contaminated by pancreatic and biliary secretions and by secondary bacterial invasion. These cause a syndrome similar to that caused by multiple diverticula of the small bowel, or to the syndrome caused by the blind loops created by surgeons in side-to-side anastomoses. Bacterial contamination of the small bowel in some way, as yet poorly understood, causes malabsorption which may also be a dominant feature in the afferent loop syndrome.

Through the administration of cholecystokinin intravenously, Swedish investigators have recently reproduced the afferent loop syndrome in patients with some degree of obstruction at this level, simply by increasing the biliary and pancreatic secretions, and causing duodenal smooth muscle contraction.

It is clear that numerous untoward mechanical and metabolic alterations combine in varying ways and degrees to plague patients after gastrectomy performed for benign disease.

Review of the methods used to treat these syndromes indicates as many forms of therapy (patient- or physician-developed) as there are patients. For the individual with mild complaints, adequate intake of the right kind of food at frequent intervals, postural aids, pharmacologic agents and patience will be effective. Often an adjustment occurs spontaneously in months or years, and the discomfort abruptly lessens. We do not know why this happens—or who will be lucky and who will be unlucky.

Some continue to empty undigested food rapidly into the unprotected jejunum where it meets fatigued biliary and pancreatic secretions, perhaps bacteria-ridden after their long afferent loop journey. These patients dump, cramp, become nauseated, sweat, have diarrhea, continue to lose weight, and certainly think unkind thoughts about the surgeon who made them this way. Yet, a surgical trick can be employed in cases unresponsive to other therapy. Henley's procedure is one of the earliest used to restore gastrointestinal continuity after a Billroth II resection. The afferent jejunal loop is divided and transposed to the duodenum, restoring more normal alimentary continuity. Since this unprotected segment of jejunum is open to recurrent ulceration, vagotomy is a necessary component of the operation.

Surgical Procedures

I do not favor the operations in which an antiperistaltic loop is interposed between the stomach and duodenum to provide an obstructing or semiobstructing segment which delays gastric emptying.

Jejunal transposition can be very difficult to perform because the surgeon who undoes the

MEDICAL AND CHIRURGICAL FACULTY

1967 ANNUAL MEETING

APRIL 19, 20, 21

THE ALCAZAR, BALTIMORE

During the Annual Meeting, scientific papers on a variety of medical subjects will be presented by **Edgar S. Gordon, MD; Walter L. Henry, Jr., MD; Philip R. Lee, MD; Richard E. Palmer, MD; Milford O. Rouse, MD;** and **John W. Walsh, MD.** One session will be devoted to a kidney symposium, at which **Ervin A. Gombos, MD,** will speak on *Clinical Problems Associated with Chronic Dialysis,* and **Joseph H. Holmes, MD,** will speak on the *Medical Problems Associated with Renal Transplantation.*

ROUND TABLE LUNCHEON

On **Wednesday, April 19,** there will be a Round Table Luncheon held at the One West restaurant. There will be 25 tables, with a different subject discussed at each.

PRESIDENTIAL DINNER

The annual Reception and Presidential Dinner will be held at the Sheraton-Belvedere Hotel on **Thursday, April 20.** There will be professional entertainment followed by dancing.

HEALTH EVALUATION TESTS

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damage often does not know how the original anastomosis was made. Adhesions are formed and loops may have become twisted, herniated or revolved in various ways. The mesenteric blood supply to the intestine is matted into the adhesive mass. This portion of the dissection can be particularly difficult. Nevertheless, with persistence, normal continuity can be restored.

Psychiatric Problems

Finally, I wish to refer to my earlier comment about the many psychiatric problems of patients with postgastrectomy syndromes. Four such patients were admitted to the hospital with very bizarre psychiatric complaints. They were afraid to eat, literally living in fear of the cramping and diarrhea which were manifestations of the severe dumping syndrome they had. Of these four patients, three have been sufficiently rehabilitated, following jejunal transposition, to return to their work, to their families and to a life of greater social ease.

* * * * *

The complex mechanisms leading to the state of gastric-invalidism following gastrectomy are reviewed. It should be noted that vagotomy and pyloroplasty occasionally result in dumping or other inadequate results, but that this occurs far less frequently than after subtotal gastrectomy with a gastrojejunostomy. Excessive criticism of subtotal gastrectomy is not intended, since most patients with such resections become well. My point is that many do *not* become well, and that *more* patients with vagotomy and pyloroplasty do. If other methods fail, jejunal transposition, increasing the size of the gastric pouch and restoring more normal alimentary tract continuity, will return most of these malnourished, postgastrectomy invalids to society.

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GASTRIC CARCINOMA

ROBERT W. BUXTON, MD
Professor of Surgery
University of Maryland School of Medicine

In recent years there has been a marked increase in the period of survival of patients who have undergone operation for gastric carcinoma. A study spanning 15 years and encompassing 257 patients shows that regional node negativeness is the only factor clearly related to long survival. The prognosis for patients with ulcerating carcinoma is mistakenly thought to be better than average. No greater survival in the cure of stomach cancer has been possible with an increase in the physician's concern for the patient with a peptic ulcer. The suspicion of gastric cancer is higher, particularly if there is a history of familial occurrence of carcinoma.

I am pleased and honored to be one of the Amos R. Koontz lecturers today.

One of the earlier speakers expressed the opinion that surgery, general surgery, had reached its apogee and was, perhaps, on the decline. I do not think Doctor Koontz would have accepted that statement without a vigorous protest; not only do I miss hearing his forthright and pithy comments, but I would like to add my own vigorous protest to the above-mentioned opinion.

I chose the subject of stomach carcinoma because I thought it appropriate to the man for whom this lectureship is named. My knowledge and recollection of Doctor Koontz is of a clinical surgeon. His approach to these patients might perhaps be characterized by a quotation from an English edition of *Theodoric Surgery* written in the 13th century:

> "Therefore, before you proceed to the treatment of the patient, consider his symptoms and if what you see is obviously bad and likely to worsen leave him alone. And, if you see good symptoms then you should not fear, and go ahead."

The prognosis of gastric cancer is generally regarded as poor; this observation is true of any neoplasm, of any organ, which has reached a state of extensive local invasion or from which spread to adjacent or distant structures has taken place. It seems obvious that the prognosis is more favorable if the lesion is localized and readily resectable. This is the basis for the observation that recovery from gastric resection may result in (a) a permanent cure, with no residual cancer, overt or occult; (b) five-year survival, but with coincident or subsequent reappearance of the tumor; or (c) fatal termination within five years from local or distant tumor which was not apparent at the time of initial operation.

Such observations have raised the speculation as to whether there are high-risk and low-risk groups of patients with gastric carcinoma and, if such groups exist, whether factors can be determined which may account for the slower growth

Amos R. Koontz, MD, Memorial Fund Lecture presented April 28 at the 168th Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland.

rates in some patients.

It has been reported repeatedly that in the last 30-35 years there has been a progressive decrease in the incidence of gastric cancer in the United States. This has encouraged many physicians to believe that within the next several decades the incidence of this entity will diminish to the vanishing point—a most pleasantly optimistic prospect. Of greater immediate significance has been the striking increase in years of survival of patients who have undergone operation for their cancer. Some appreciation of this modest improvement is apparent in the patients studied in this paper.

In order to determine some of the factors which seem to affect the outcome of patients with cancer of the stomach treated by operation, all of the patients seen at the University of Maryland Hospital from 1950 through 1965, a fifteen-year period, have been reviewed (Fig 1). This amounts to 257 patients.

The number of patients admitted to this hospital have generally and slowly increased each year; the patients with cancer of the stomach have varied widely and do not give an absolute picture of progressively decreasing frequency.

In spite of the possibility of longevity with this disease, the attitude of many physicians has been one of pessimism and discouragement. This is clearly the attitude which concerned Wangensteen when he wrote, "Of patients who come to resection for gastric cancer, the majority (75%) exhibit metastases to lymph nodes." He went on to report, however, that of "patients with gastric cancer exhibiting no lymph node involvement, there are 50% five-year survivors." These contrasting statements are of utmost importance in our approach to the patient with possible gastric carcinoma, for in the two statements lies the only clearly expressed advantage of early definitive operation.

Equally as discouraging as lymph node positiveness are two other groups of patients in this present study. Of the 257 individuals (Table 1) 18% (46 patients) were not suitable for operation, and one-third (85 patients) were considered unresectable at the time of operation. Thus, 50% of the patients, when first seen by us, could not be helped in their disease.

Although the physicians' part in the delay is

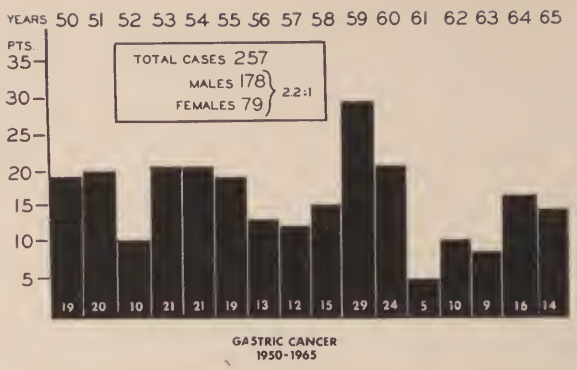


Fig 1

never completely clear, it was possible to document some instances of this. Forty of the patients in the series were known to have a peptic ulcer. Since commonly these are gastric ulcers, it is of interest to point out that four (10%) in this sub-group were duodenal ulcers. Four patients were followed, without operation, to their deaths with their ulcer/carcinoma.

It is sometimes said that the prognosis, in general, for long-term survival in the patient with ulcerating carcinoma is better than under some other circumstances. Among our patients this does not appear to be so inasmuch as ten patients, or one-third of those who were operated upon (Table 2), lived three years or more while only five

CARCINOMA STOMACH
1950-1965

DISTAL STOMACH		221 PTS.
NO OPERATION	40 PTS.	
EXPL. and BIOPSY	77 PTS.	
PALLIATIVE RESECTION	39 PTS.	
DEFINITIVE OPERATION	65 PTS. (30%)	
ESOPHAGOGASTRIC JUNCTION		36 PTS.
NO OPERATION	6 PTS.	
EXPL. and BIOPSY	8 PTS.	
PALLIATIVE RESECTIONS	9 PTS	
DEFINITIVE OPERATION	13 PTS. (36%)	
		257 PTS.

Table 1

CARCINOMA STOMACH
1950-1965

TREATED AS PEPIC ULCER 4 DU.; 36 GU. = 40 PTS.
(4 PTS. DIED ⊼ OPERATIONS; 5 PTS. DIED POST-OP.) = 9 PTS.
(13% OP. MORT.)
SURVIVED OPER. = 31 PTS

AVERAGE SURVIVAL.....27 MONTHS
LONGEST SURVIVAL.....8YRS.; 1 MO.
(1/3 PTS. SURVIVED 3 YRS.; 1/6 PTS. SURVIVED 5 YRS.)

Table 2

patients (16%) lived five years or longer. Four patients in this series, however, have died of diseases other than recurrent carcinoma; in two of these, necropsies failed to show recurrent carcinoma at one year and 4½ years, and it is presumed that all four individuals were cured of their cancer by operation.

Forty-eight patients with cancer at all sites within the stomach were operated upon with the hope that some definitive procedure could be carried out (Table 1). In each the surgeon was able to accomplish a palliative resection only, leaving known tumor within the abdomen. Some of these patients were known to have had their gastric lesion for a long period. They compose 18.7% of the entire group. The average survival in this group of patients is six to nine months, but seven patients lived more than one year, and two of these are known to have lived more than five years. By contrast the average survival of patients who had operation without resection was 4.6 months, five patients lived more than a year and one of these lived longer than five years.

It would appear that several of the above patients had tumors which showed a remarkably slow rate of growth and that if they had been seen when somewhat less advanced, or if a more aggressive resection had been attempted, indefinite survival might have been achieved for a few. Lest one be too critical of the surgeons who operated upon these patients, it is well to record that adeno-carcinoma was present in one of the biopsied liver nodules from the longest surviving patient.

It seems proper to suggest that one of the most important, and to some extent the most controllable, factor in the future of the patient with gastric cancer is the spread to regional and distant lymph nodes. It is perhaps incorrect to suggest that early diagnosis and treatment are directly related to node positiveness or negativeness and yet, in truth, and in a large number of patients, this is so.

CARCINOMA STOMACH
1950-1965

DEFINITIVE RESECTION....65 PTS.
(DISTAL STOMACH)

POSITIVE NODES.....28 PTS.
5 PTS. LIVED >5 YRS...18 %
1 PTS. LIVED >10 YRS... 4 %

NEGATIVE NODES.....37 PTS.
9 PTS. LIVED >5 YRS....24 %
5 PTS. LIVED >10 YRS...14 %

Table 3

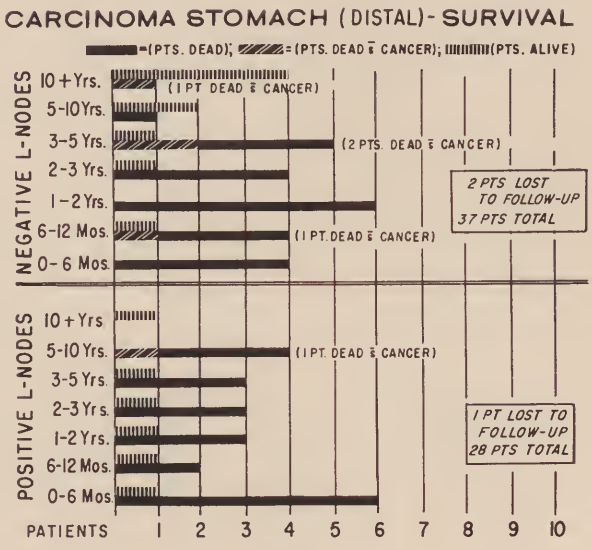


Fig 2

Of the patients in this study with carcinoma in the distal stomach, 30% (65 patients) were considered suitable for resection for cure (Table 3); 28 (43%) of these had no evidence of cancer in lymph nodes removed by operation. The patients with negative nodes lived an average of 10 months longer and, as might be anticipated, the five- and ten-year survivals were much more numerous (Fig 2).

It seems useless to compare these patients with those whose lesion is at the esophagogastric junction except for the fact that in both instances the operative mortality rate is appreciable (Table 4), though three times greater in the higher location. Finally, it is well to observe that long-term survival is possible and attainable when the lesion arises high within the stomach.

Of much interest has been the attempt to determine the effect of heredity on these patients as indicated by a family history of carcinoma. In 79 patients we are without a clear history of the familial presence of cancer. Of the remaining patients, one out of five, or 20%, had a familial occurrence of carcinoma—in one or more relatives. In 15 patients there was known familial

CARCINOMA STOMACH
1950-1965

CARCINOMA ESOPHAGOGASTRIC JUNCTION.....13 PTS.

OP. MORTALITY (4 PTS.).....30%

3 YR. SURVIVALS.....2 PTS. (22%)

5 YR. SURVIVALS.....1 PT. (10%)

Table 4

gastrointestinal carcinoma (Fig 3) and in 5 there was carcinoma in the stomach of parent or sibling. In these patients the resectability was the same as in the over-all group (33%), 7 patients survived more than one year, 4 more than three years and 2 patients have lived more than ten years.

Thus, this group of individuals follows much the same pattern as the larger sampling. However, the familial history of cancer in one of five patients suggests a substantial number of patients in whom the physician should be intensely concerned when a series of symptoms or clinical findings suggest a gastric neoplasm.

One of the outcomes of this study has been the recognition of an unusual carcinoma in a single patient. In 1948 there appeared a report by Steiner et al, of an undifferentiated special type of carcinoma described by them in six patients. Five of their six patients were men. In each instance the tumor was associated with a good prognosis. Histologically the tumor was composed of masses and solid cords of cells with irregular pale nuclei and little cytoplasm. The stroma was rich in chronic inflammatory cells and the cancer cells were densely basophilic. The tumors were called "blue cell cancer." Their histogenesis could not be defined by special staining techniques. One of the six patients had lymph node metastasis.

In our own series there is one patient, a Negro male, now alive more than 15 years with this type of tumor. At the time of gastrectomy there were lymph node metastases present. This patient was readmitted and his abdomen reexplored in 1964 because of acute intestinal obstruction. At that time a careful search for metastatic or residual gastric carcinoma was made and none was found. This patient is an example of a unique tumor which is indeed associated with a good prognosis.

Conclusions

The items which appear to contribute to long survival and cure from gastric carcinoma have

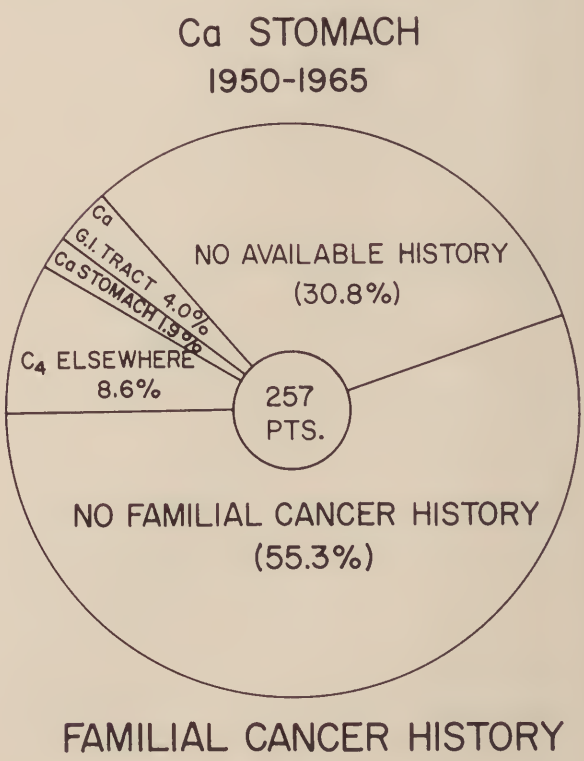


Fig 3



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been explored. In 257 patients except for one with a peculiar carcinoma cell type, "the blue cell carcinoma," the only fact relating clearly to long survival is regional node negativeness.

In this study 70% of our patients were unsuitable for operation, had unresectable lesions at operation or had palliative operations only. Thus, only 30% had potentially curable lesions when first seen by the surgeon.

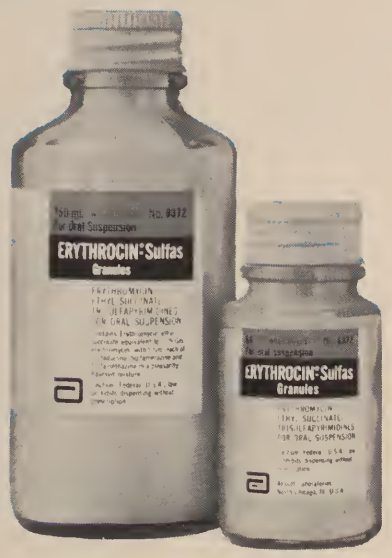
From our review it appears that a family history of cancer, particularly of the gastrointestinal tract, may lead to early suspicion and earlier diagnosis in some patients with gastric cancer.

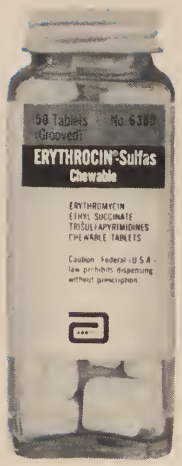
The presence of peptic ulcer, particularly gastric ulcer, has served to alert us to the possibility of gastric cancer. In this series such an ulcer has not improved prognosis in such a patient. This should serve to remind the physician that early surgical treatment is the only effective cure for ulcerating gastric carcinoma.



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The diagnoses were multiple in some cases and were chiefly bacterial infections of the respiratory tract.

Dosage was maintained from three to 10 days; average treatment was five days. All of the ill children accepted the orange-flavored suspension favorably.

53 were clinically cured within 72 hours, while 32 showed partial relief within the same time, and subsequent clinical cure.

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A clinical cure rate of 97.7%

1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

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Brief Summary on next page

ERYTHROCIN®-SULFAS
Brief Summary

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or newborn infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

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COMPONENT MEDICAL SOCIETIES

WASHINGTON COUNTY

The Washington County Medical Society held its annual meeting on November 3, 1966, at the Venice Motel. The following were elected to office for 1966-1967:

President: **Richard T. Binford, MD**
President-elect: **John H. Kehne, MD**
Vice-president: **Edward W. Ditto, III, MD**
Secretary: **John W. Clark, MD**
Treasurer: **Sidney Novenstein, MD**
Board of Censors: **John J. Dobbie, MD**
Delegates: **Harold H. Gist, MD**
Ralph H. Williams, MD
Alternates: **James R. Dwyer, MD**
Robert M. Russell, MD

* * * * *

J. Walter Layman, MD, was honored for fifty-years-plus membership in the Washington County Medical Society. He joined the group in November, 1913. He will receive a pin from the society as a token of its esteem.

* * * * *

Thomas V. Craig, MD, and **John J. Donoghue, MD,** attended the meeting of the American College of Surgeons in California in October.

Joseph C. Crisp, MD, attended the Mid-Atlantic regional meeting of the American Urological Association held at the Greenbriar in White Sulphur Springs, West Virginia, in October.

Gerald LeVan, MD, attended the Southern Medical Association meeting in Washington, DC, in November.

Richard A. Young, MD, attended the meeting of the American Academy of Pediatrics held in Chicago in October.

* * * * *

Philip J. Hirshman, MD, has officially retired after forty years in the general practice of medicine. He has now been elected to emeritus membership in the Washington County Medical Society. Our best wishes to him for a happy retirement.

As part of the Washington County Medical Society's effort to expand health education, it selected a large three-dimensional ear model with description of ear anatomy and common ear conditions for the Health Fair. How sound travels and the effect of motion were described. The exhibit was set up in conjunction with the Hearing Testing Trailer. The fair was held at the North Hagerstown High School November 12 and 13, 1966.

John W. Clark, MD

WICOMICO COUNTY

Richard D. Bauer, MD, president-elect of the Medical and Chirurgical Faculty of the State of Maryland, and **John Sargeant,** executive secretary of the Faculty, were guest speakers at the November meeting of the Wicomico County Medical Society, Inc. Current and projected plans of the Faculty were the subjects.

Arrangements have been completed for **William Weglicki, MD,** of Baltimore, to be the featured speaker for Day with Doctors, a medical career program for high school students, which is jointly sponsored by the Wicomico County Medical Society and the Heart Association of the Lower Eastern Shore. Students from Wicomico and other lower shore counties will participate in the two-day meeting, which is scheduled for December 9 and 10.

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1967 ANNUAL MEETING
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These findings are reported by the Health Insurance Plan of Greater New York in the December 19, 1966, issue of *Journal of the American Medical Association.*

During an 18-month study of 110,000 men and women, 301 men suffered a first myocardial infarction, the report said.

"Fifty per cent of the least active men who smoked cigarettes were dead within four weeks of (the attack), compared with 28% of the smokers with higher levels of physical activity," the report said.

For nonsmokers, the corresponding figures were 56% for the least active men and 17% for those who were relatively more active.

From an AMA news release, Dec 19, 1966.



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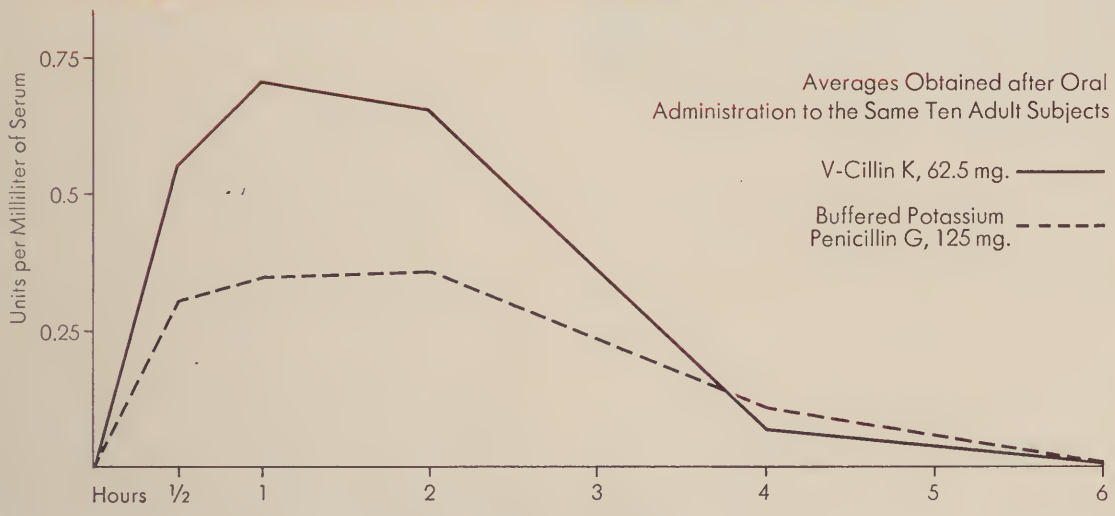
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Penicillin V	0.02	0.02-0.04	0.02	0.003-0.4	0.01	0.005-0.2
Penicillin G	0.02	0.005-1.6	0.005	0.002-0.2	0.02	0.01-0.1
Methicillin	1.6	0.4-6.3	0.2	0.1-0.4	0.2	0.1-1.6
Oxacillin	0.4	0.1-3.1	0.04	0.02-0.4	0.1	0.04-0.8
Cloxacillin	0.2	0.2-0.8	0.1	0.1-0.8	—	—
Nafcillin	0.4	0.2-0.8	0.04	0.02-0.1	0.02	0.02-0.2
Ampicillin	0.2	0.1-0.8	0.02	0.01-0.04	0.02	0.01-0.04

Adapted from Klein, J. O., and Finland, M.: New England J. Med.,269 1019, 1963.

with high blood levels, even in the presence of food



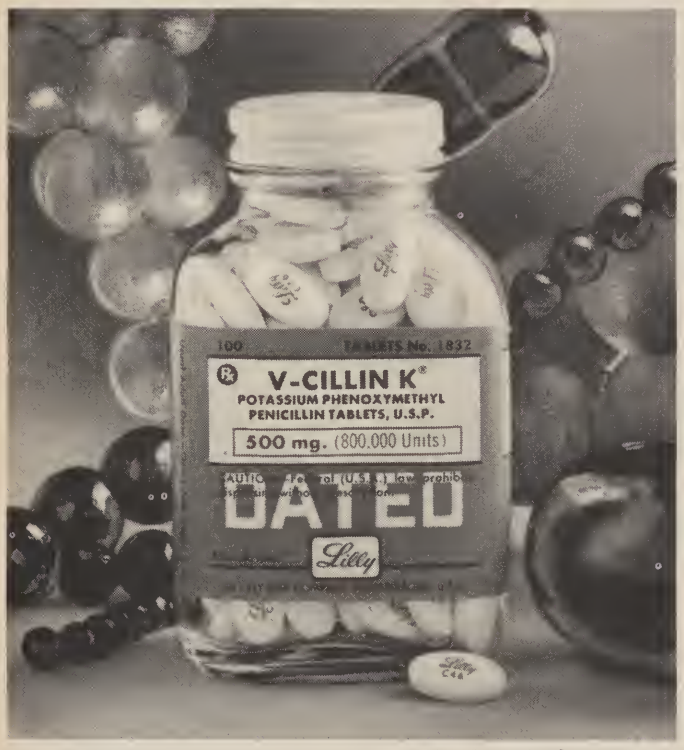
Adapted from Griffith, R. S , and Black, H. R.: Current Ther. Res., 6:253, 1964.

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V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

Indications: V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy. Reactions occur more frequently in individuals with bronchial asthma or other allergies or in those who have previously demonstrated sensitivity to penicillin. If hypersensitivity reactions occur, the drug should be discontinued.

Adverse Reactions: Although serious allergic reactions are much less common with administration of oral penicillin than with intramuscular forms, skin rash, symptoms resembling those of serum sickness, or other manifestations of penicillin allergy may occur. When penicillin is administered, measures for treating anaphylaxis should be readily available. Those include epinephrine, oxygen, and pressor drugs for relief of immediate allergic manifestations as well as antihistamines and corticosteroids for delayed effects.

The use of antimicrobial agents may be associated with the overgrowth of antibiotic-resistant organisms; in such a case, antibiotic administration should be stopped and appropriate measures taken.

Administration and Dosage: For Tablets V-Cillin K and for V-Cillin K, Pediatric, the usual dosage ranges from 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, the daily dosage may be 50 mg. per Kg. of body weight divided into three doses.

Beta-hemolytic streptococcus infections without associated bacteremia may be treated with 200,000 to 400,000 units three times a day. Therapy should be continued for a minimum of ten days to prevent development of rheumatic fever and/or other serious complications. Dosage for routine streptococcus prophylaxis in patients with a history of rheumatic fever or congenital heart disease may be 200,000 units once or twice daily. When such patients undergo tonsillectomy, tooth extraction, or other minor surgery, the prophylactic dose should be 500,000 units every six hours given two days prior to surgery and for two days postoperatively. If oral medication is not feasible on the day of surgery, parenteral therapy should be considered. Mild to moderately severe pneumococcus pneumonia has been treated effectively with 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be given every six to eight hours in conjunction with indicated surgical procedures.

For gonorrhea in males, 500 mg. (800,000 units) every six hours for three doses may be employed; in females, 500 mg. every four hours for six doses are recommended. Patients with a suspected lesion of syphilis should have a dark-field examination before receiving penicillin and monthly serologic tests for a minimum of three months.

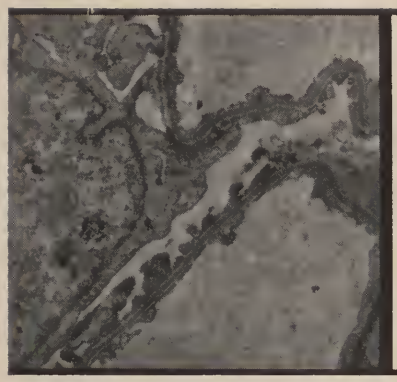
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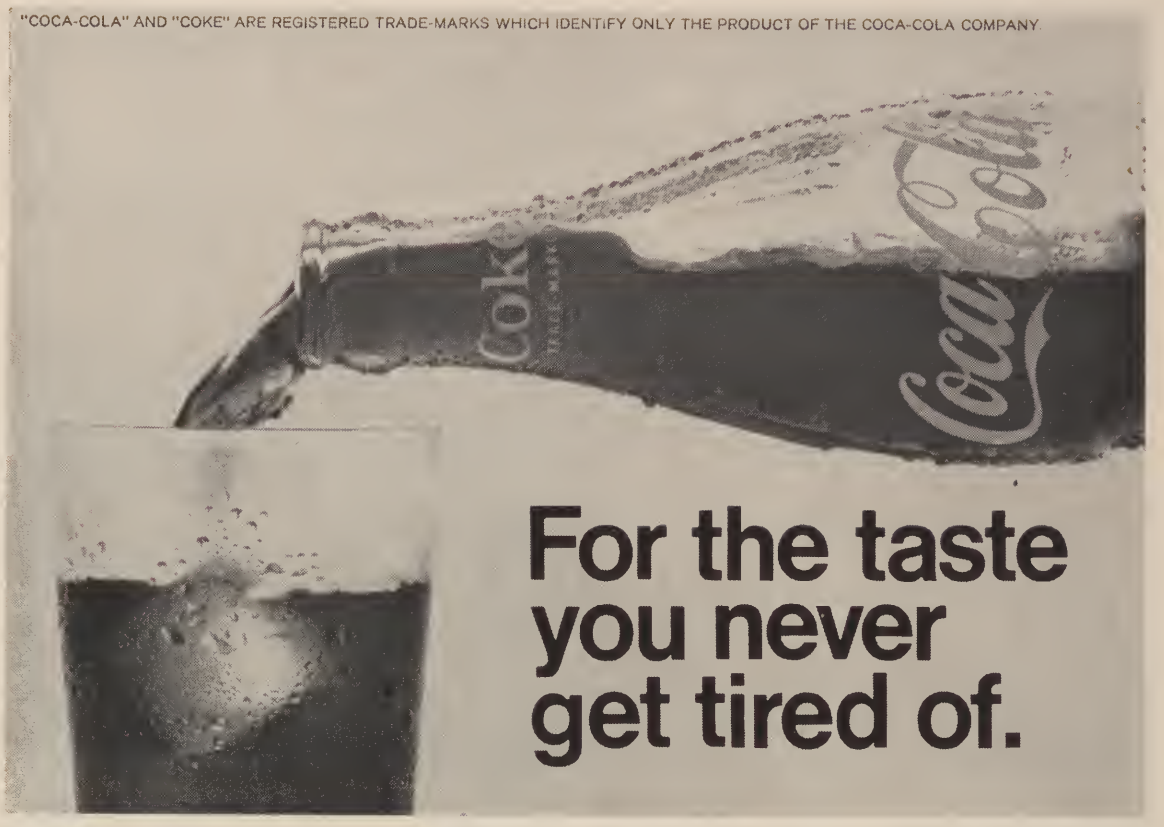
Will Pathology Be At the Center of a Core Curriculum?

MITCHELL J. ROSENHOLTZ, MD

Subsequent to World War II, stimulated by the now well-known curricular experiments at Western Reserve School of Medicine, the undergraduate medical school curriculum has come under increasing scrutiny. The accelerated pace of such review appears at present to be directly related to a variety of forces, clearly outlined in the Coggeshall Report.[1] These forces include demographic and economic factors, the growth of specialty practice, the increasing institutionalization of practice, the remarkable proliferation of medical knowledge, obvious improvements in both secondary and college curricula, and changes in the patterns of disease in our population. Another very important contributing force is the pressure of the legislative and executive branches of the Federal Government to support new mechanisms to speed the application of biomedical research to the bedside of as many patients as possible. This force has become especially apparent since the Report of the President's Commission on Heart Disease, Stroke, and Cancer.

From the standpoint of the pathologist, several of the curricular revisions presently in operation or recently proposed are of particular interest. Cope and Zacharias,[2] for example, have edited a most exciting, if not speculative, monograph describing the Endicott House Summer Study on Medical Education which took place in 1965. At that "retreat" in which 35 educational administrators and educators, mainly from medical schools, participated for two weeks, four subcommittees each proposed hypothetical curricula in the light of the general discussions at the Summer Study. Certain themes which run through several, if not all, of the four curricula, seem significant. They include (1) medical school and college curricula of only three years each; (2) more clear-cut coordination of medical school and house staff educational experiences, often all under the control of medical school faculties; (3) a disciplinary or organ approach to course organization, rather than a departmental one; (4) a striking increase, compared to the present, in elective offerings allowing for very diversified experiences for each student; and (5) the presentation, usually in the first year, of a course emphasizing the "biology of disease."

A course in the Biology of Disease might well be expected to receive its leadership and main impetus from a department of pathology, and to draw its support from a wide range of other departments, including, for example, internal medicine, biostatistics, microbiology, physiology, biochemistry, etc. Pathology's leadership would very probably revolve around a "case method" approach, emphasizing the many implications of a given disease process. Clearly, then, the other basic sciences, besides pathology, would be expected to present a course experience for their graduate students very different from the one for the medical students. Such a first-year course itself would act as preparation for the student's activities in the second year, which would emphasize clinical clerkships not dissimilar to those



now a part of many schools' third year curricula.

In contrast to the Endicott House Curricula, the curriculum which began at Duke in the present academic year would not put pathology in such a central role. Rather, all six basic sciences are presented in the first year, with each stressing only that "core" of material which seems "essential" for all medical students to understand. Such "core" courses have been presented in the last two years in several disciplines, including pathology, as part of Duke's otherwise classical curriculum. They have apparently been successful. Only time will tell if the Duke freshmen, a very able student body, can tolerate all six core courses in one year.

Finally, mention should be made of the curricular revision in progress, and under study, at the University of Maryland School of Medicine. Only the first year program is in actual operation. In it, anatomy, physiology, and biochemistry run side by side with every attempt being made to coordinate the presentation of material, mainly on an organ system basis. Selected topics in biophysics and pharmacology are also presented.

The Curriculum Committee proposals for the years subsequent to the first are now under active discussion. Their similarity to certain of the Endicott House suggestions seems clear. For example, at Maryland it is suggested that the second year be more fully coordinated and, for the most part, revolve around the pathology course which, for almost ten years, has laid heavy emphasis on a "case" approach. A further suggestion of the Curriculum Committee is a course in Pathologic Physiology and Clinical Coordination which would precede the more classical clinical clerkships. Almost certainly, the pathology department would be an active participant in such a coordinated "preclerkship."

In conclusion, it seems very likely that, both at the University of Maryland and at many other medical schools, departments of pathology will be playing very critical roles in curricular revision in the next decade. This trend may be expected to be especially prominent in those schools which attempt to present courses in Biology of Disease early in the medical school experience.

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2. Cope, D., and Zacharias, J.: *Medical Education Reconsidered*, Philadelphia: J. B. Lippincott Company, 1966.

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WILSON L. GRUBB, MD, Chairman

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Practical Aspects of Antimicrobial Therapy

MOHSEN ZIAI, MD
Associate Professor of Pediatrics
The Johns Hopkins University School of Medicine

The antimicrobial agents are two-edged swords. While remaining as important weapons in the fight against many infections, they carry with them potential hazards and limitations. With their improper use, it is possible to induce morbidity and cause mortality. In order to use antimicrobial agents properly, it is important to know the manner in which they work and the objectives of their administration.

In a previous article* the mode of action of these drugs has been discussed. In the present communication an attempt will be made to derive certain practical conclusions and explain how, with the use of these agents, the offending organisms can be destroyed with the least possible harm to the patient.

A. *Irrational treatment*—Because of many erroneous assumptions, antibiotics are the most inappropriately used of all presently available drugs. Certain clarifications are therefore needed:

(1) Antibiotics are not antiseptics and must not be used as such.

(2) Improper use of antimicrobials contributes to serious, sometimes fatal, sensitivity reactions and/or emergence of resistant strains.

(3) Drug combinations, except under specific therapeutic circumstances (enterococcal endocarditis, tuberculosis, brucellosis), are often useless and may even be hazardous.

(4) Prophylactic antibiotics are indiscriminately used and can be potentially dangerous except in certain selected situations.

(5) Pharmacological data on antimicrobial agents which are gathered in adults are not necessarily applicable to infants and children. Unless the safety of each specific agent (including a critical evaluation of the dosage) is established, it may be dangerous to use these drugs.

(6) Antibiotics are not substitutes for surgical drainage.

(7) Antibiotics should not be used in the treatment of undiagnosed fever unless the evidence points to the infectious nature of the illness and the patient's life is in danger.

(8) It is important to provide the necessary supportive therapy and not assume that the antibiotics will do all the work.

(9) New and more expensive drugs are not necessarily superior to the old established agents.

(10) In choosing between two equally effective drugs, it is important to consider the cost,

**Mode of Action of Antimicrobials* by the same author, PEDIATRICS, THE JOURNAL, Vol. 15, No. 12.

the availability and toxicity of each.

B. *Rational Use of Antimicrobials* — Ideally, the physician should know the nature of the offending organism and the anatomical sites of infection in order to choose the proper drug. This is unfortunately not always possible. Bacterial cultures and sensitivities may not be available, and when they are obtained, treatment may have to be started before the results are known. Certain general considerations that follow may therefore assist in the formulation of the therapeutic regimen.

Unless the patient's life is in danger, it is best to delay antimicrobial therapy until the etiological diagnosis can be made with some confidence, so that the selection of the therapeutic agent can be accomplished logically. It is generally important to be familiar with the specific organisms, the clinical pictures which they usually produce, and the antimicrobial sensitivity of these organisms in the particular geographical location. For example, the organism most likely to cause the first bout of urinary tract infection in a child is E coli; in almost all cases, such an infection is susceptible to sulfonamides and tetracyclines. In contrast, the small infant whose mother has recently been hospitalized with staphyloccocal abscesses, and who becomes ill with a severe pulmonary infection, is probably suffering from a resistant staphylococcal pneumonia and is best treated with one of the penicillinase-resistant penicillins.

An important step in the laboratory determination of the specific etiology should consist of obtaining a gram stain — a simple procedure which is often by-passed.

Another common infection which can be used as an illustration is tonsillitis. Since a frequent bacterial etiology would be group A beta hemolytic streptococcus, the physician decides to treat the patient with antimicrobials. It becomes mandatory not to use any drug but penicillin or, in case there is a history of allergy to this agent, erythromycin; in either case the drug must be used in full dosage and for a sufficiently long period (10 days). In a young patient the main purpose of such treatment would be the prevention of rheumatic fever and nephritis. Other drugs do not fulfill this purpose.

In known infections it is wise to use one specific drug. In this way toxic effects, including sensitivity reactions as well as emergence of resistant strains, are reduced and the cost to the patient is minimized. Combinations of antibiotics are helpful only in rare instances of known synergism, and when there is a mixed infection. The commercially available mixtures must not be used, however, because they usually contain an inferior product, and the amount of each drug is usually not sufficient for the specific infection against which it is directed.

Knowledge of the specific drug pharmacology is important. When two agents seem to be especially effective against a specific infection, the one that achieves better concentrations at the site of infection, eg, subarachnoid space, would be preferable. The patient's own defense mechanisms, his age, and the physiological state of his various systems involved in drug pharmacology, are added considerations. For example, in the presence of renal failure the choice of a nephrotoxic drug, or one that depends on renal excretion, would be unwise.

In the neonatal period and in prematures, the administration of drugs and the calculation of dosages is especially critical if such complications as gray spinal syndrome, due to chloramphenicol, and kernicterus, due to sulfonamide therapy, are to be avoided.

Prophylactic use of antimicrobials has proved to be effective only in the following specific situations:

(1) Penicillin in gonococcal and syphilitic infections, meningococcal infections, rheumatic fever in susceptible individuals, pneumococcal infections in agammaglobulinemia, and endocarditis in susceptible subjects.

(2) Antimalarial prophylaxis in endemic regions.

(3) Antituberculous drugs in patients with known previous tuberculous infections who are undergoing stressful situations, eg, an operation or an attack of measles.

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REHABILITATION Notes

REHABILITATION SECTION
BALTIMORE CITY MEDICAL SOCIETY,

DOUGLAS G. CARROLL M.D.
EDITOR

Evolution of Hand Function

DOUGLAS G. CARROLL, MD
Chief, Physical Medicine and Rehabilitation
Baltimore City Hospitals

A major concern of a department of physical medicine and rehabilitation is the restoration of upper extremity function following trauma, reconstructive surgery, arthritis, burns, amputations and a number of neurological diseases.

Over the next few months in REHABILITATION NOTES, we will be concerned with what hand function is, how it is deranged in various diseases, and what the aims of therapy are. These notes will attempt to draw attention to the nature and significance of the loss of function rather than to a specific program of treatment. An understanding of the nature of impairment in hand function in various diseases should promote more effective treatment programs.

* * * * *

Function, in the physiological sense, pertains to the normal or special action of any organ or part of a living animal. A number of attempts have been made to identify and describe the characteristic normal hand function in Primates.[1-6] Basic to any theory of the evolution of hand function is a description of hand function in serially higher members of the primate series.

Methods

In each of the species selected, an attempt will be made to compare its hand function with hand function in a normal human hand. The assumption will be made that the hand test described by the author[6] includes the major significant functional activities of the human hand. There are several difficulties in attempting to apply this test to lower forms. In the first place, not enough observations have been made on hand activities in lower primates to know whether or not they can perform certain of the activities in the hand test. Secondly, the test was designed for the human and therefore is not entirely appropriate to animals of different size and strength.

Hand Function in Primates

In the earliest forms of land animals, there is already a differentiation between the fore and hind limbs. The fore limbs, used for digging, propulsion, grasping, and clinging, are more mobile than the hind limbs, which are used for pushing. The pelvis tends to be more stable than the shoulder girdle.

A purely terrestrial life led to increasing stability of all the limbs with loss of the clavicle, loss of radial and ulnar rotation and loss of digits (as seen in the hoofed animals).

Arboreal life, on the other hand, led to more mobility of the shoulder, more rotation of the forearm and finer prehensile function.

The author would like to thank William L. Straus, Jr., PhD, professor of anatomy and physical anthropology at the Johns Hopkins University School of Medicine for his guidance in the preparation of this article.

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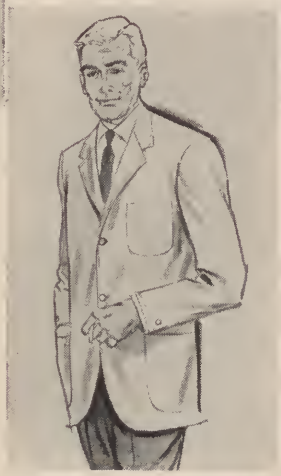
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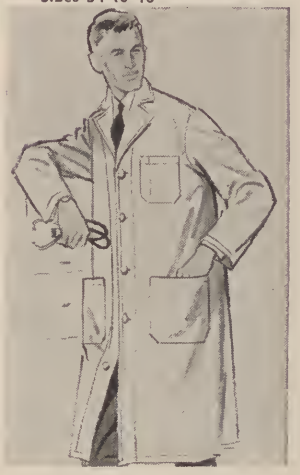
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ARTHRITIS ADVANCES IN 1966 CITED

In 1966, news of progress in arthritis research moved off dead center and offered genuine hope, for the first time in years, that science is on the right track. Fresh clues gave strong support to the idea that arthritis—in some of its most painful and crippling forms, at least—is due to infection—something which might be prevented or counteracted without too much difficulty. This assessment of progress was made by William S. Clark, MD, president of The Arthritis Foundation, in a year-end report. He pointed also to important recent advances in drug therapy for arthritis sufferers.

"I know of no year since 1948—when recognition of the rheumatoid blood factor triggered a new line of research—in which so much has happened pointing to a specific answer to the arthritis mystery," Dr. Clark said: "I don't want to raise false hopes but I honestly feel there is solid ground for new optimism."

Arthritis in its various forms affects 13 million Americans, more than five million of them suffering from rheumatoid arthritis, according to Dr. Clark.

From an Arthritis Foundation news release, Dec, 1966.

The following is a description of what is known about hand function in various primates in an ascending order.[7]

1. **Tree shrews:** These small agile, large-eyed, arboreal, squirrel-like animals were previously included in some classifications with the Insectivora. Modern classifications have included them as the family Tupaiidae in the Infraorder Lemuriformes (Suborder Prosimii). *Tupaia glis* moves easily over small branches. The clawed hand holds onto large branches by digging in the claws. Small branches are held by clasping twigs toward the palm with the digits. The Tupaiidae are the only primates which have convergent hands.[1] In a convergent hand the fingers are arranged in a fan. They separate from each other on extension; when they flex they converge. The fingers act as a whole without individual movement and take the shape of the object around which the fingers converge. This species has the maximal variability of grasp of all primates. *Tupaia glis* can pick up food in one hand, but rarely does so.

2. **Lemurs:** The lemurs are, in a sense, intermediate forms between the tree shrews and the monkeys. The lemur resembles the shrew in its rhinarium and medial lip cleft. It resembles the monkey in the use of the hand and foot for grasp. Unlike the tree shrews, lemurs generally have flat nails on at least some digits. Some forms show a greater degree of specialization than higher primates. The pollex, rudimentary in some, varies in length and in degree of separation from the second digit (d2). D2 and d3 show lesser variations.[8] The thumb may be widely separated from the index finger, opposite the other digits, and may reach the ulnar digits when grasping a branch; however, the thumb metacarpal moves on a hinge-joint in only one plane.[1] Wood Jones[9] described the truly opposable thumb as the human thumb, that is, one of which the metacarpal can be rotated through a wide arc on the carpus. The thumb of these lemurs is therefore not truly opposable. In many Lemuriformes and Lorisiformes observed by Bishop,[1] a large part of the ball of the thumb can be brought into contact with the ball of d2 and d3. Prosimians, however, do not pick up objects by pinch between the balls of two digits.

In the lemur hand the phalanges of the thumb flex at the same time as do those of the other digits. There is no individual control of the digits. This is called whole-hand control.

Recent lemurs show relative elongation of the fourth digit of both the hand and foot. This lengthening is associated with a thumb opposed to the other digits and possibly allows an increased span of the grasping hand around a branch. Associated with these changes is a rearrangement of the interosseous muscles around d4 as the axis.

Lorisiform lemurs tend to grasp small objects between the ends of the digits and the distal palmar pad whereas Lemuriform lemurs tend to pick up small objects between the finger pads and the proximal part of the palm. All of these actions, however, occur by whole-hand control. There is a single prehensive pattern with a multiplicity of grips.[1]

3. **Tarsius:** This is the only living genus of the superfamily Tarsioidea (infraorder Tarsiiformes) although there are a number of fossil forms. There is still no agreement on *Tarsius'* taxonomic status, but it appears to be somewhere between the lemurs and the monkeys. Hand activities are of the whole-hand control type.

4. **Ceboidea:** The New World or platyrrhine monkeys are nearly all arboreal. They have whole-hand control. Generally the thumb flexes in the same plane with the other fingers and is not pseudo-opposable.[1]

Some forms (*Cebus* and *Cacajao*) can use the sides of d1, d2 and d3 to manipulate small objects. They can also grip with flexion of d1 around the object. Other species (*Ateles* and *Lagothrix*) can pick up small articles by closing two fingers in a scissors grip.

5. **Cercopithecoidea:** The Old World or catarrhine monkeys are divided into two large groups: the subfamily Cercopithecinae (macaques, baboons, mandrills) and the subfamily Colobinae (langurs). Two new developments in hand function are seen in the Cercopithecoidea. The thumb can be used for precision movements by pressing against the side of the hand or d2.

UPPER EXTREMITY FUNCTION

Estimated performance of primates (in ascending evolutionary sequence) in a hand test standardized for man. The test is applied to each upper extremity individually. Only one extremity is included for brevity.

Basic Function			Maximal score	Tupaia glis	Potto	Tarsius	Cebus	Papio	Chimpanzee	Homo sapiens
GRASPING	1.	Block 4″	3	0	0	0	0	0	3	3
	2.	Block 3″	3	0	0	0	0	0	3	3
	3.	Block 2″	3	2	2	2	2	3	3	3
	4.	Block 1″	3	2	2	2	2	3	3	3
GRIPPING	5.	Pipe 1¾″	3	3	3	3	3	3	3	3
	6.	Pipe ¾″	3	3	3	3	3	3	3	3
LATERAL PREHENSION	7.	Slate 1″ x ⅝″ x 4″	3	0	0	0	2	3	3	3
	8.	Turn key right	3	0	0	0	0	2	3	3
	9.	Turn key left	3	0	0	0	0	2	3	3
PINCHING	10.	Ball 3″	3	3	3	3	3	3	3	3
Marble ⅝″	11.	Index Finger	3	2	2	2	2	3	3	3
	12.	Middle Finger	3	0	0	0	0	0	0	3
	13.	Ring Finger	3	0	0	0	0	0	0	3
	14.	Small Finger	3	0	0	0	0	0	0	3
Ball Bearing ⅜″	15.	Index Finger	3	2	2	2	2	3	3	3
	16.	Middle Finger	3	0	0	0	0	0	0	3
	17.	Ring Finger	3	0	0	0	0	0	0	3
	18.	Small Finger	3	0	0	0	0	0	0	3
Ball Bearing ¼″	19.	Index Finger	3	0	0	0	2	3	3	3
	20.	Middle Finger	3	0	0	0	0	0	0	3
	21.	Ring Finger	3	0	0	0	0	0	0	3
	22.	Small Finger	3	0	0	0	0	0	0	3
Ball Bearing ⅛″	23.	Index Finger	3	0	0	0	0	3	3	3
	24.	Middle Finger	3	0	0	0	0	0	0	3
	25.	Ring Finger	3	0	0	0	0	0	0	3
	26.	Small Finger	3	0	0	0	0	0	0	3
PLACING	27.	Washer over nail	3	0	0	0	0	2	2	3
	28.	Iron to shelf	3	0	0	0	0	2	3	3
SUPINATION and PRONATION	29.	Pour water from pitcher to glass	3	1	1	1	1	1	2	3
	30.	Pour water from glass to glass (Pron)	3	1	1	1	1	1	2	3
	31.	Pour water back to first glass (Supin)	3	1	1	1	1	1	2	3
	32.	Write name (dominant hand only)	3	0	0	0	0	0	0	3
ARM PLACING (Score 1 if completed)										
	33.	Place hand on head in midline	1	1	1	1	1	1	1	1
	34.	Place hand behind head in midline	1	1	1	1	1	1	1	1
	35.	Place hand behind back to midline	1	1	1	1	1	1	1	1
	36.	Place hand to mouth	1	1	1	1	1	1	1	1
		TOTAL	100	24	24	24	28	45	57	100

SCORING ITEMS 1 TO 32

3—Performs test normally.

2—Completes test, but uses abnormal movements, takes abnormally long time or has great difficulty. (Abnormal movements include using grasp instead of grip in items 5 & 6, pinch in items 7, 8 or 9, lateral prehension in items 11 to 26).

1—Performs test partially.

0—Can perform no part of test.

Cercopithecus and *Erythrocebus* have relatively short thumbs and pick up small objects between the thumb and the side, rather than the ball, of d2. D2 and d3 are not controlled independently.

In *Cercocebus albigena,* as well as macaques and baboons, the ball of d1 is used against the ball of d2 in fine picking movements. In these groups the index finger, as well as the thumb, is independently controlled. In the baboon there may be separate control of all digits.[1]

6. **Hominoidea:** Anthropoid apes and men have a high degree of fine control with independent control of the digits and some power to place the ball of d1 against d2.

The final major development in the hand was rotation and true oppostion of the thumb. Brachiation apparently discouraged the development of the thumb[10] and because of this fact, there is some reason to question man's descent from brachiators.[11,12]

A world-wide decrease in forests and expanded grasslands may have accounted for the desertion of the trees by some primates. The use of bipedal locomotion in an upright position would then have released the hands from any locomotor duties. The upper extremities would then have become available to carry, gather and handle weapons, food and tools.

Napier[2] suggests that earliest man had power grip between the thenar eminence and the four fingers, but lacked precision grip between the balls of the thumb and the other four fingers. He suggests that the ability to rotate the thumb into a position opposite the fingers was limited in early man, but evolved as man used the hand for precision purposes.

Some time in the Early Pleistocene age (perhaps as early as about 2 million years ago, if recently determined dates for Olduvai Gorge, Tanganyika, are correct) man changed from a tool-user to a tool-maker. The development of sedentary cultures with town, agriculture and commerce, probably started in the eastern Mediterranean basin around 9,000 years ago—about 2,000 years after the end of the last glacial age in Europe.

The development of the brain, the hand, binocular vision and speech allowed man enormous development of imagination, tempered by experience, informed by conceptual tools and disciplined by the scientific methods. Progress in hand function has resulted from the development of powers already anatomically present in monkeys, but not in use. Wood Jones[9] has pointed out that the monkey hand has all the muscles, joints and bones necessary to perform all the motions that man can perform with his hand.

Estimated Scores of Lower Primates in Human Upper Extremity Function Test

The table shows a test developed for evaluation of hand impairments in man.[6] From what is known of hand activity in the primates,[1,4,5] an estimate of what they could do in the hand test has been attempted. A tree shrew (*Tupaia glis*), a lemur (*Potto*), *Tarsius,* a New World monkey (*Cebus*), and Old World monkey (*Papio*), a great ape (*Chimpanzee*) and *Homo sapiens* have been selected to illustrate differences in hand function. Items 1 to 4 consist of lifting blocks of various sizes from a flat table to a shelf at the rear of the table. This is best performed by a hand in which the thumb is opposite the fingers, but the thumb does not have to be truly opposable. In the tree shrew the larger blocks could not be handled because of their size. The fingers of the shrew are able to close around small objects; however, this would be a clumsy way in which to handle the blocks, and the tree shrew is given a score of only two out of three on this test. It is not until one reaches the anthropoid apes that one finds a hand large enough, and with a thumb in the position, to arch the largest block.

Items 5 and 6 require gripping two pipes in holders. These activities can be done well by all primates.

Items 7, 8 and 9 test lateral prehension, pronation and supination. Turning a key in a lock requires finger tip control between d1 and the side of d2. This can be done only by the Cercopithecoidea, the anthropoid apes and man.

Items 10 to 26 test the finest movements, that is, pinch between the balls of various fingers and the thumb. A ball three inches in diameter can be handled by most species fairly well. When it comes to pinch between the thumb and the other digits, only man can do this with any facility. The baboon and possibly the macaque are suspected of having independent control of d3, d4 and d5,[1] but it is doubtful that they could pick up small objects

between the ball of d1 and the ball of d3, d4, or d5 individually.

Items 27 and 28 consist of placing, first, a washer and, secondly, a heavy iron in various positions. Most of the primates are unable to lift a washer from a flat table. The iron requires power grip which is available to most primates, but the iron actually used in this experiment is too heavy to lift for all except the larger monkeys and anthropoid apes.

Items 29 to 31 consist of pouring water from a pitcher to a glass, picking up a glass and pronating and supinating it. This activity can be performed by some of the anthropoid apes but not without spilling and clumsiness.

Item 32, writing the name, has not yet been accomplished by species other than man.

Items 33 to 36 are designed to test shoulder and elbow mobility and can be performed by all primates.

Discussion

Despite the inaccuracy of grading the various primates included in this table, and despite the fact that the test may not be an accurate conspectus of man's hand activity, it is nevertheless clear that there is a very remarkable difference between what the higher monkeys and anthropoid apes are able to perform (or commonly perform in their everyday activities) and the rich variety of hand activity available to and used by man.

Current research in the field of hand evolution has been largely concerned with comparative anatomical features of the hand.[7,8,9] A few attempts have been made to relate form to function.[1–4] This paper has attempted to see hand function in lower forms in relation to hand function in man. The major advantages of man's hand are the opposability of the thumb to the tips of the fingers and individual finger movement. It is possible that this crude attempt to compare hand function in Primates may lead to a more accurate description of hand function.

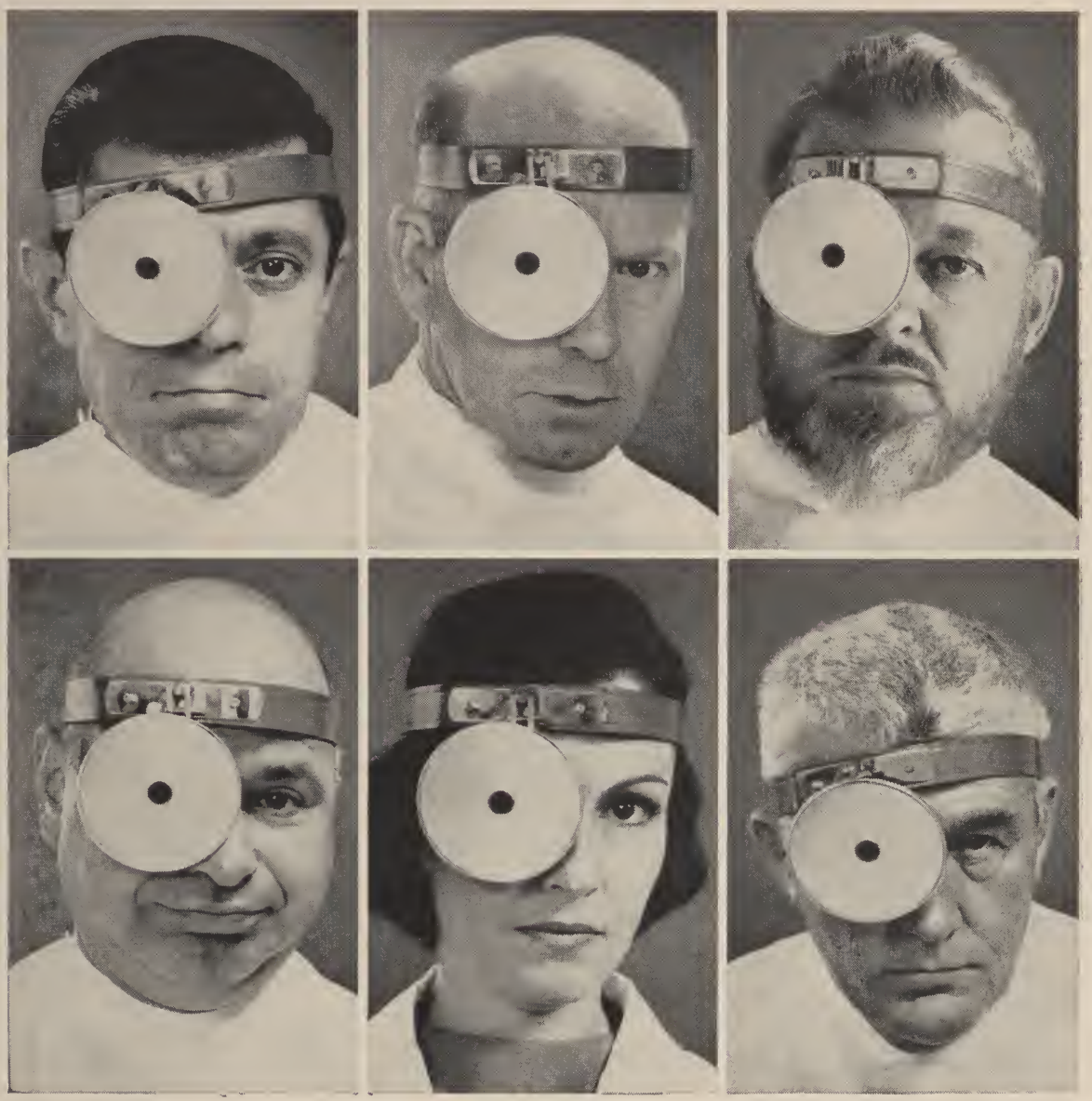
It is a curious observation[9,13] that the rhesus monkey has a hand that has all the physical (muscle, nerve and bone) structures necessary to perform all the functions performed by the human hand, yet lacks the association areas in the brain to synthesize and coordinate movements necessary for tool-making. It is as though the hand were awaiting the development of the brain to be put to full use. One wonders how such a remarkably complex structure, with potential function far beyond its actual use by the rhesus, could develop from natural selection. For natural selection should tend to eliminate all those functions not needed to meet important challenges demanded by the environment.

Summary

A description of hand function in serially higher members of the primate series has been summarized from the literature and compared with hand function in man. The important activities of man's hand are grasp (between thumb and the opposed digits), grip (flexion of digits and thumb around an object), lateral prehension (between thumb and radial side of digit 2), and pinch (between the ball of the thumb and digits 2 to 5). The truly opposable thumb and the individual control of the digits give man unique five-precision movements.

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the HEART PAGE

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Elijah Saunders, MD—*Editor*

Prosthetic Replacement of Heart Valves

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The prognosis of cardiac patients with acquired valvular heart disease has been altered favorably since the introduction of prosthetic valves. Although a large number of prosthetic valves are available, the Starr-Edwards caged ball valve prosthesis has been subjected to human implantation more often than any other prosthesis. This report summarizes the clinical experience with this prosthetic valve at the University of Maryland Hospital.

One hundred and twenty-four patients underwent prosthetic valve replacement during the past four years, 77 having mitral valve replacement, 36 aortic valve and 11 replacement of both aortic and mitral valves. So far we have not replaced any tricuspid valves, although 4 patients included in the present series had plication of insufficient tricuspid valves, simultaneously with replacement of mitral and/or aortic valves. The patients varied in age from 20 to 68 years, the majority being between the fourth and sixth decades of life. In mitral valve disease the indications for valve replacement were restenosis after adequate valvulotomy, severe calcification, mitral insufficiency, and combined stenosis and insufficiency of significant degree.

In aortic valvular disease the indications for valve replacement were incapacitating symptoms (congestive heart failure, angina, etc), hemodynamic evidence of severe stenosis and/or insufficiency. The latter was considered hemodynamically significant in the presence of a wide pulse pressure and marked regurgitation by cineangiography. Most patients were subjected preoperatively to right and left heart catheterizations to assess the significance of the lesions. The majority of patients with mitral valve disease had combined stenosis and insufficiency whereas the majority of patients having aortic valve surgery had predominantly aortic stenosis.

The technique of cardiopulmonary by-pass which is required for valve replacement has been greatly simplified with the use of hemodilution, since it minimizes the need for large quantities of heparinized fresh blood.

The immediate survival rate (within 30 days of surgery) in mitral valve replacement was 80%,

and in aortic valve 66%. Only 4 patients with double valve replacement survived surgery. The beneficial result of surgery was maintained in the long term follow-up of patients with aortic valve replacement. In the mitral group, however, the delayed complications leading to mortality decreased the survival rate from 80% to 60%. These complications are due mostly to thromboembolic disease, prosthetic detachment and bacterial endocarditis related to the prosthesis. Our experience so far suggests that long term anticoagulation and elimination of all foci of infection both pre- and postoperatively have significantly diminished these complications.

Although the mortality and morbidity associated with valve replacement appear high when compared with other types of surgery, we recognize that most of these patients are categorized as Class III and IV according to the American Heart Association functional classification, and are severely ill. If better results are to be obtained, it would seem advisable not to allow patients with acquired valvular heart disease to progress into functional Class IV before being offered the benefits of valve replacement.

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MOTHERS AND ASTHMA

Psychiatrists have generally agreed on one primary cause of childhood asthma: the mother. Something in the mother's personality sets off the child's dark, hidden fears and anxieties, the theory goes. This, in turn, produces allergic reactions in the child which constrict the bronchial tubes and make breathing difficult or even painful.

But what kind of woman is involved? To better describe her, 14 psychiatrists, pediatricians, and clinical psychologists were asked to sort and choose from among 100 definitions of the asthmatogenic, or asthma-causing mother. A report on their definitions appears in a current publication of the American Medical Association, the December issue of the *Archives of General Psychiatry*.

"On the whole," the report said, "clinicians tend to agree that the asthmatogenic mother is concerned with her own adequacy, is self-defensive, protective of others, sensitive to demands, in need of reassurance from others, irritable, and tends to feel guilty."

She is further described in the report as "not calm and relaxed, not submissive, not skilled in the social techniques of play and humor, and as neither rebellious nor non-conforming." The authors stress, however, that asthma is a complex phenomenon. Its cause cannot entirely be blamed on the mother. In some instances the children's physical makeup seemed to be more a cause of their asthma than their psychological relationships with their mothers, the report said.

The authors are Jeanne Block, PhD, Elinor Harvey, MD, Percy H. Jennings, MD, and Elaine Simpson, MA.

From an AMA news release, Dec 26, 1966.

"Take a laxative" is a harsh sentence

Although there are more than 60 ethical laxatives available for the constipated patient, many, unfortunately, do not really produce an effect much like a normal bowel movement. Instead they whip the bowel, torment it and leave it irritated, inflamed and exhausted.
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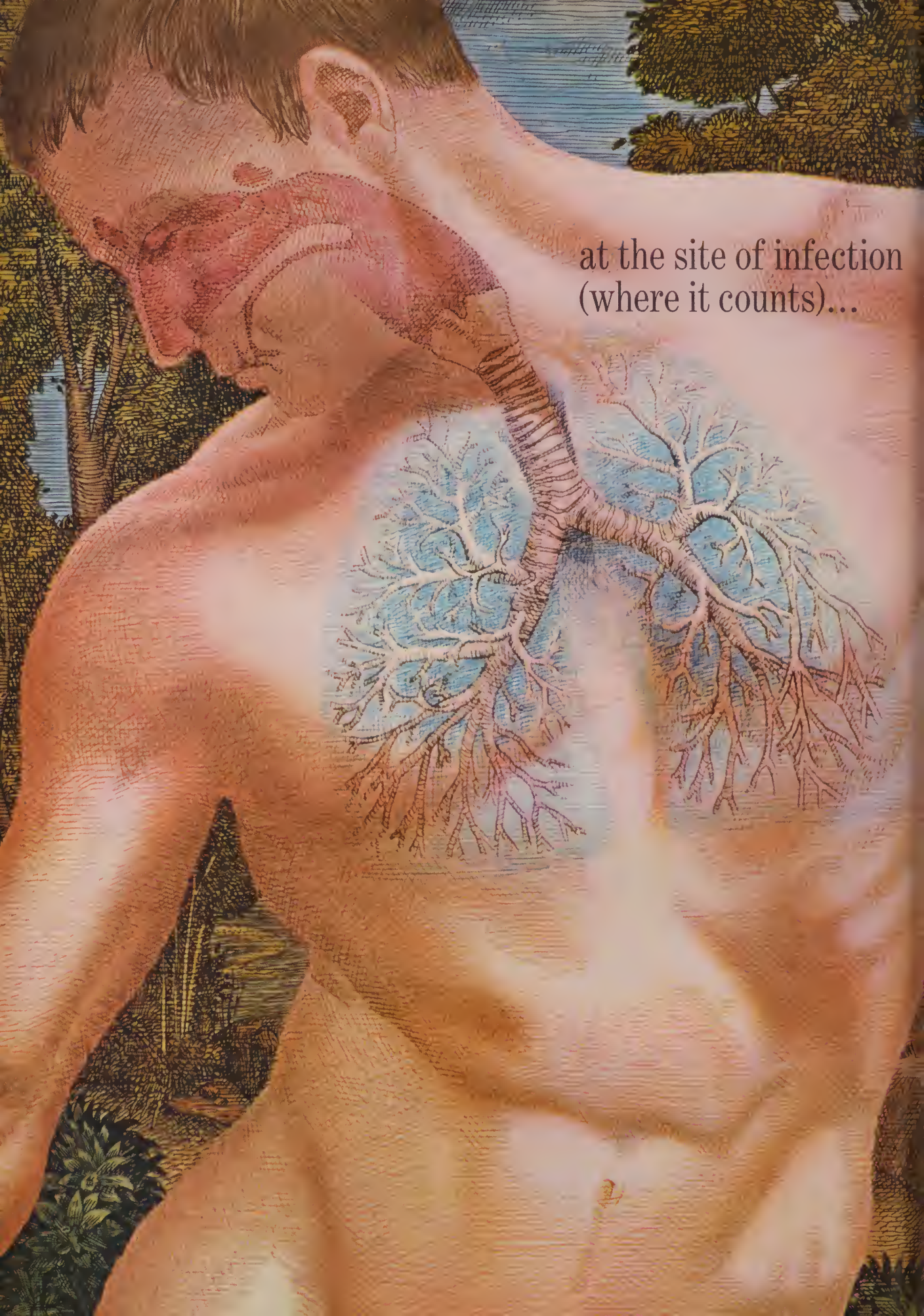
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Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

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Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Side-Effects: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have appeared in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly if the drug is readministered to sensitive patients, usually within forty-eight hours. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appeared to be definitely related to use of the drug, laboratory findings we characterized by increased direct-reacting bilirubin, elevat alkaline phosphatase levels, negative or weakly positive cephal flocculation and thymol turbidity tests, elevated serum glutar oxalacetic transaminase levels, peripheral eosinophilia, and n mal cholecystograms.

Individual idiosyncrasy seems evident since jaundice has n been reported in other patients taking prolonged courses of t medication. Patients with chronic infection have been given 1 to 2 Gm. of the drug daily for periods of two to six months, a patients with rheumatic fever have taken prophylactic doses 0.5 Gm. daily for two years without difficulty. In one group 144 patients who received the drug daily for two years, no jau dice was noted. It was of interest that members of six of the patients' families, who were not taking the drug, had episod of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels we determined in a group of fifty-four adults and children who to 250 mg. of Ilosone daily for an average of sixteen months rheumatic fever prophylaxis. The results were compared wi those of a similar group of forty-four patients who received pe icillin. There were no cases of jaundice in either group. Elevati of SGPT and serum alkaline phosphatase levels during the cour of treatment was observed in one patient treated with Ilosо and in two patients treated with penicillin. Seven other patie in the group receiving Ilosone and four others in the penicill group showed elevations in one of the tests at some time duri administration of the drugs.

Very satisfactory therapeutic results, without toxicity, we reported in 102 pediatric patients who received short-term (te day) courses of Ilosone in the treatment of streptococcus inf tions. Results of liver function tests in these patients were co parable to those in a similar control group who had receiv penicillin.

Gastro-intestinal disturbances not associated with hepatic e fects are observed in a small proportion of individuals as a res of a local stimulating effect of the medication on the alimenta tract; however, the normal intestinal gram-negative bacteri flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with the u of erythromycin, there have been occasional reports of urticar skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orally.

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For adults and for children over fifty pounds, the usual dosa of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythromyc therapy should be considered.

In the treatment of syphilis, the recommended total dosage 20 to 30 Gm. given in divided doses for a period of ten to fifte days. Close follow-up of the patient is necessary since erythr mycin drugs have not had adequate evaluation in all stages syphilis. Examinations of spinal fluid are recommended as pa of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four days a recommended. In the treatment of gonorrhea, patients with suspected lesion of syphilis should have a dark-field examinati before receiving antibiotics, and monthly serologic tests shou be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and 250 m (equivalent to base), in bottles of 24 and 100.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to base in bottles of 50.

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Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equivale to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size packag

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:69, 19
2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:398, 19
3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 1960.

Additional information available to physicians upon request.
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Alcoholism SECTION

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

Emergency Help Needed for Poisoned People

VERNELLE FOX, MD
Medical Director, Georgian Clinic
Atlanta, Ga

One of the most pressing needs not only in the Atlanta area but also, I am sure, in every community in the state, is for detoxification centers. What is a detoxification center? It is a small medical unit geared to treat people with all kinds of poisoning, and it logically should be run in conjunction with the emergency rooms of general hospitals and staffed by especially trained personnel.

People in urgent need of such a facility range from paying private patients to those who cannot afford medical care; and this includes those with overdoses of drugs, poisons and/or alcohol—whether by accident or suicide attempts. These patients are acutely and severely ill, and may die if not treated immediately and adequately. Most people would need a detoxification center for only two to four days before they could either go home or go to a general medical or psychiatric facility.

One of the tragedies of our society is an alcoholic who is sincerely trying to get off a "bender" and who is unable to secure sufficient help to get detoxified in order to become "clear" enough to get to a clinic, Alcoholics Anonymous, or any other source of help. He is caught in a medical rat maze—help is there if he could be helped to get it!

Reprinted with permission from *THE NEW LIFE*, publication of The Alcoholic Rehabilitation Service of Georgia.

Even if he has money and a private physician, his doctor and the hospital are frequently unable to offer him the needed help because they do not really know how to treat him. If the hospital had a detoxification unit, the physician could have the help of especially trained nurses and attendants, and the hospital would probably not be so hesitant to accept him.

If he is without money, he should be able to receive the services of the City Hospital like any other patient. He is as sick and has as great a chance of dying as does the patient recovering from surgery. All too frequently this is not the case. As it now stands, a fellow may be picked up by the police, held in jail for four hours, and then turned loose. This four hours sobers him up just enough for him to be sick and a candidate for the hospital. But, since the needed facilities are not available, he is turned into the street or "does time," as the case may be. Neither one contributes to his recovery in the vast majority of cases.

Recent Federal District Court rulings have indicated that the sentencing of an alcoholic for simple drunkenness is illegal. We have long known that sentencing for drunkenness was useless more often than not. This ruling is eventually



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going to make all communities look at the alternatives, and a logical place to begin is to have available adequate medical attention for the sick, "poisoned" individual who is trying to get detoxified.

It is high time to stop hiding behind the idea that "he got himself into this, now let him get himself out." The diabetic who has been off his diet "got himself into" acidosis, but we still offer him good medical attention. The time has also passed for those of us interested in the care of the alcoholic to stop sitting and fussing about the fact that "doctors and hospitals won't treat them" and begin to look at why services are not available.

There are many factors involved in this and they undoubtedly vary in each community. Very certainly, one common area is the lack of "know how." This "know how" can be developed in a small group of "specialists." In other words, a team consisting of a few nurses and a doctor from any hospital could be trained in this specialized area. Another common problem is the fear of disrupting the hospital's routine by the admission of a "drunk." This too, could be avoided by a detoxification unit as a "drunk" isn't drunk after twenty-four to seventy-two hours, but is either well enough to go home and/or to clinics, or is sick enough to be in a general medical bed.

Another factor in the past has been the hospital's fear, often based on experience, of being "stuck" with the patient for an indefinite period of time. Today, almost every community has a good Alcoholics Anonymous group and, very rapidly, more and more Health Departments will have clinics. Patients can be referred to these agencies as soon as they are physically able, and the general hospital does not need to undertake his long-term care.

What can each of us do in our community to interest responsible people in evaluating the situation in our own facilities? If local groups were to study the existing situation and needs and use a little imagination, I feel sure they could devise a way of tackling the problem.

It is time to stop merely being critical of the lack of services, and to start looking determinedly for ways and means of being useful to those who can help treat people in stages of acute poisoning, including alcoholism.

DEPARTMENT OF HEALTH
STATE OF MARYLAND
William J. Peeples, MD, MPH, *Commissioner*

HIGHLIGHTS

Women's Conference on Health

Approximately 60 women recently attended a two-day Public Health Conference for Women Leaders, conducted by the Department's Health Information and Education Services. To encourage community interest in health issues and cooperative support of health programs, the conference featured pertinent presentations by the Commissioner, the Deputy Commissioner and various program directors, followed by small group discussions.

Enthusiastic response indicated a desire for further health symposia and intentions to investigate local needs and to enlist the active participation of other organizations.

Grant for Air Survey in Allegany County

Federal approval has been received of the application for a three-year grant requested for an air quality survey in Allegany County. Funds allowed by the Division of Air Pollution, U. S. Public Health Service, amount to $24,843 for the first year. This will be combined with $8,281 in State and local funds for a total of $33,124 for this project in its initial year.

Solid Waste Disposal Project

Another joint Federal-State-local activity now under way in Allegany County is a three-year demonstration project using abandoned strip mines as landfills for disposal of solid wastes. With the help of a $126,318 grant from the U. S. Public Health Service and the leasing of a 21-acre strip mine by Allegany County Commissioners, the Division of Solid Wastes hopes by project termination to demonstrate satisfactory means not only of refuse disposal, but also of land reclamation and reduction of surface water pollution by mine acid drainage. Included in the three-year plan is the experimental combination of sewage sludge with solid wastes. Laboratory testing of ground and surface water samples will be done in cooperation with the Department of Water Resources.

Success of the project may open the way to use of approximately 2,240 acres of abandoned mine pits in western Maryland for solid waste disposal.

Medical Care Studies Chief Appointed

Dr. Miriam Sachs has been appointed Chief, Division of Medical Care Studies, a post created under the recent reorganization as an outgrowth of the Department's responsibility for quality of care under Title XIX.

Dr. Sachs received her MD degree from the Columbia College of Physicians and Surgeons and her MPH degree from Columbia School of Public Health and Administrative Medicine. She has served in several capacities with the New Jersey State Department of Health, including District State Health Officer of the Metropolitan District, and with the U.S. Public Health Service. She is a diplomate of the Board of Preventive Medicine

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and Public Health and of the Board of Occupational Medicine.

Family Planning Standards Published

The Department granted permission to the National Planned Parenthood Association to publish, and distribute nationwide, copies of "Standards and Procedures of Family Planning Service and Clinics." This "Guide for Local Health Departments" was developed jointly by the Department's Divisions of Public Health Nursing and of Maternal and Child Health.

Shortage of Physical Therapy Assistants

Returns from surveys of health care facilities in the State indicate that two hundred physical therapy assistants could be used immediately, if they were available. The Division of Physical Therapy is cooperating with the American Physical Therapy Association of Maryland in developing a training program to provide assistant manpower for physical therapists and other professions concerned with restorative and rehabilitative services. This is not expected to be accomplished until 1968, however.

Birth Rate Continues Decline

During 1965, there were 4,866 fewer babies born to Maryland residents than in 1964. The 74,137 total is the lowest recorded since 1956, according to the *Annual Vital Statistics Report, 1965*. Declines were registered in all but two counties, reflecting a nationwide downward trend which began in 1957.

Deaths occurred at the rate of 8.7 per 1,000 population, a rise of two percent over the 1964 rate. The chief causes—heart disease, cancer, and stroke—showed small increases, while deaths from accidents and cirrhosis of the liver rose considerably. Infant mortality reached an all-time low of 24.8 per 1,000 live births.

Copies of the report are available from the Division of Biostatistics, Maryland State Department of Health, 301 West Preston St, Baltimore, Md 21201.

BALTIMORE CITY HEALTH DEPARTMENT

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Medical History Capsule

Robert E. Farber, MD, the city's commissioner of health, placed a "medical history capsule" in a vault in a lobby wall of the new Mount Vernon Medical Building in a special ceremony on November 29. Inserted in the metal capsule were copies of US Public Laws 89-97 and 89-239, and of the current issues of *The Journal of the American Medical Association,* the *Maryland State Medical Journal,* the Baltimore City Medical Society *Bulletin* and the city's daily newspapers.

In commenting on its contents, Dr. Farber said, "The two public health laws which have been included in this capsule . . . represent probably the most significant health legislation passed by the Congress of the United States since the original Social Security Act of the early 30's. These laws have the potential for radically changing the practice of medicine as we have known it in this country . . . medicine is at the gateway of a new era which will be of great benefit to the people of the United States."

The capsule, which is destined to be opened by the city's commissioner of health in the year 2066, will be identified by a plaque on the sealed wall.



Robert E. Farber, MD, inserting capsule to be opened in 100 years.

Maternity Project

The Maternity and Infant Services Project 501 of the Baltimore City Health Department has been expanded by the addition of eight social workers. This will enable the Baltimore Maternity Center to provide enough social workers in the health district clinics to assure (1) identification of the social problems of more patients in the maternity and infant groups, and (2) follow-up on all patients with such problems until the baby is one year of age.

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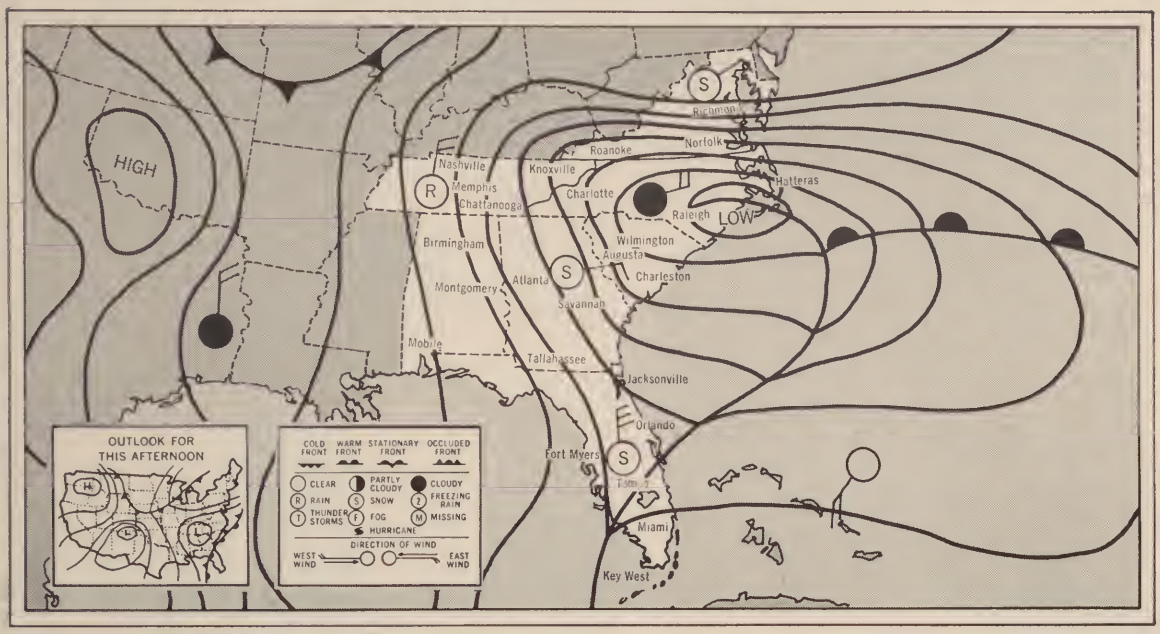
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cent patients, all patients requesting adoption information, and all patients with a history of mental illness, mental retardation, or housing and financial problems, are screened by a social worker, who ascertains the nature and the severity of the problems so that patients can be referred to the agencies best able to assist them. The expansion will allow better use of, and coordination with, such services as the Department of Public Welfare, Public School No. 1 for pregnant school girls, and the social services departments of hospitals and private adoption agencies. If these services are for some reason not available to certain patients, the Maternity and Infant Services Project 501 will be able to give assistance through its own program.

Social work services in the Maternity Project are under the supervision of Mrs. Naomi H. Evans, newly promoted to Chief of Social Services. The Baltimore Maternity Center is located at 211 West Lombard Street; the telephone number is 752-7282.

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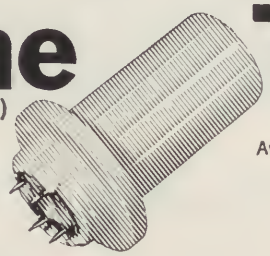
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Department of Mental Hygiene

Isadore Tuerk, MD, Commissioner

Kurt Gorwitz, Statistics Director

The Hospitalized Adolescent

Last year more than 400 children between the ages of 12 and 17 were treated in Maryland's mental hospitals. This is equal to one out of every 1,000 Maryland residents in this age group.

The following table shows the distribution of resident patients (as of July 1, 1965) by diagnosis, age and length of hospitalization. Half were diagnosed as transient situational personality disturbance, one out of six as schizophrenic, and one out of eight as personality disorder. Although most were recent admissions, a number had been under inpatient care for extended time periods.

The adolescents in state mental hospitals represent only a small proportion of those seen in psychiatric facilities. Data available through the Maryland Psychiatric Case Register indicate that 11.5% of all admissions 10-17 years of age were to state hospitals, 6.1% to other inpatient facilities, and 82.4% to clinics. However, they do represent a major portion of those receiving treatment since many of the adolescent admissions to outpatient facilities are seen only for testing, evaluation and diagnosis.

A study released in 1962 indicated a minimum need for 500 residential beds for children,* a number far in excess of the then available resources. In addition to the Institute For Children, which now has 86 patients (most are less than 12 years of age), separate units for adolescents with a combined capacity of 66 are now functioning at the Crownsville and Spring Grove hospitals. The

*Health and Welfare Council of the Baltimore Area, Inc.: *Residential Psychiatric Treatment For Children In Maryland.*

		DIAGNOSIS			
AGE AND LENGTH OF HOSPITALIZATION	Total	Schizophrenia	Personality Disorders	Transient Situational Personality Disturbance	All Others
12-14 Years Of Age	74	12	5	39	18
-1 month	7	1	—	4	2
1-11 months	48	6	5	27	10
1 year	12	2	—	6	4
2 years or more	7	3	—	2	2
15-17 Years Of Age	135	22	22	63	28
-1 month	21	4	6	9	2
1-11 months	87	13	14	42	18
1 year	21	3	2	10	6
2 years or more	6	2	—	2	2



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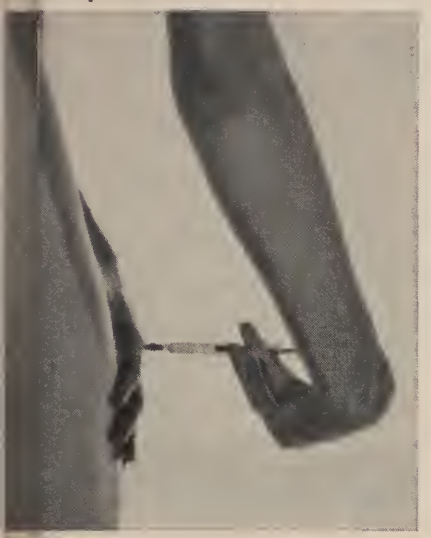
former has also established a day care program for a small number of disturbed children from one county. Because of the bed shortage, the majority of adolescents continue to be treated in the same wards with other patients—a policy which is not believed to be conducive to the recovery of either group. Efforts to remedy this chronic deficiency must involve additional construction and staffing both in State hospitals and in other facilities, as well as the close coordination of services with schools and all other present and proposed community resources.

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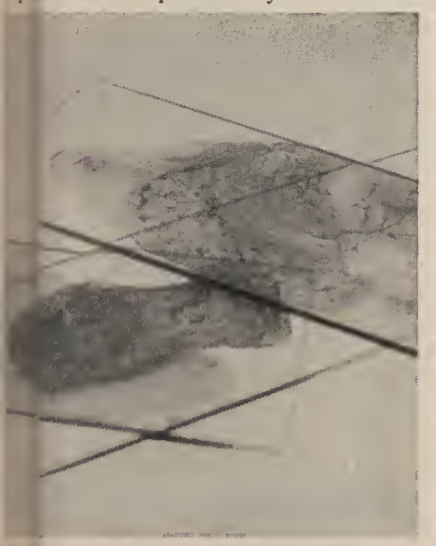
2. nonpregnant women with a history of recent or recurrent monilial vaginitis



3. elderly or debilitated patients



. patients with a past history of moniliasis



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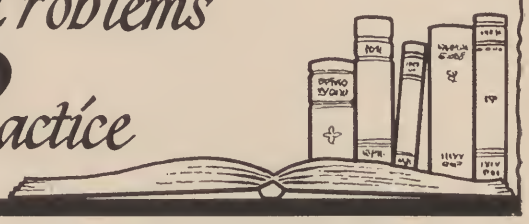
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The Keogh Plan: The New Amendment

WILBURN L. McCLURE, JR.

When the President's signature was affixed to "The Foreign Investors Tax Act of 1966" it brought into law several variegated and unrelated amendments. One rider, introduced by Rep. Eugene J. Keogh, was an amendment to the Self-Employed Individual Retirement Act.

Originally the self-employed law permitted the annual contribution of as much as 10% of "earned income" to a retirement fund. There was a ceiling on contributions of $2,500 a year and 50% of that amount, or $1,250, was tax-deferred.

Beginning January 1, 1968, the new law permits the self-employed individual to deduct the *full amount* of his contributions up to 10% of his "earned income" but not to exceed $2,500.

Originally "earned income" (for purposes of the 10% limitation) could not exceed 30% of the net profits *where capital as well as services* was a significant element in the production of income.

Beginning January 1, 1968, the new law defines "earned income" as the net earnings from self-employment. In other words, the 30% limitation no longer applies to restrict the amount of the contribution.

Many self-employed individuals, compelled to include one or more employees in their plan, discovered that the deductible limitation on their own contributions minimized or voided any annual net savings. Some found that contributions toward employees' plans would result in an overall loss, and they therefore did not establish such a plan.

The Self-Employed Individual Retirement Act, as amended, continues to permit employees to enter the plan if certain conditions exist. Even though the plan has been liberalized to increase benefits for the employer, the phase of the law concerning employees should be closely examined, especially by doctors in partnerships before a contract for a plan is signed. Depending upon the number of employees and the percentage of contributions made, employers may continue to find serious limitations where it is mandatory to include the employee in the plan.

Most doctors know the benefits that might be derived from a "Keogh Plan," particularly if they have no employees. Many others have found increased benefits by including their wives when they work as a full-time nurse or secretary. (The latter procedure requires close coordination between the plan salesman and the doctor's tax advisor and, in some cases, the help of the doctor's advisor on estate management.)

Caution: The Keogh Plan, as originally written into law and with its most recent changes, while certainly attractive to many doctors, needs detailed evaluation prior to commitment. Like every other "good thing," this one is not suitable for all comers.

Mr. McClure is director of the Baltimore office of Professional Business Management, Inc. This monthly column is prepared as a complimentary service to the *Maryland State Medical Journal.*

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JANUARY, 1967 MRS. HARRY L. BERMAN, *Editor*

Baltimore City

One of the many activities of the Woman's Auxiliary to the Baltimore City Medical Society is Project Handclasp. Presently under the supervision of Mrs. Joseph B. Workman, chairman of the auxiliary's International Health Committee, it has functioned since 1956 with the cooperation of the Christian Overseas Mission Hospitals, a non-profit organization handling a sample drug program.

Physicians or their wives take drug samples to the Medical and Chirurgical Faculty Building at 1211 Cathedral Street for collection and storage. When there is a sufficient amount, Mrs. Workman takes them to her home where, with the professional guidance of Dr. Workman, the drugs are sorted, separated and evaluated for shipping, in accordance with the strict rules of the Federal Drug Administration.

* * * * *

Mrs. H. Leonard Warres, auxiliary representative to the Faculty's Public Relations Committee, reported at the November 30th meeting of the auxiliary's board of directors that the possibility of bringing the S.S. HOPE to Baltimore was being explored by the Committee. Mrs. Warres also reported the highlights of the Seminar on the Medical Aspects of Traffic Safety [See p. 45. Ed.], which she had attended on October 12 in her capacity as chairman of the auxiliary's Safety Committee.

* * * * *

During National Community Health Week, at the request of the Medical Society, auxiliary members distributed 100 posters advocating careers in medicine and allied fields. They were displayed in schools, hospitals, libraries and community stores.

* * * * *

On November 14 and 15, thirty-five BCMS auxiliary members and their friends provided voluntary help at the Diabetic Detention Clinic in the Fifth Regiment Armory. They considered this a most gratifying experience.

* * * * *

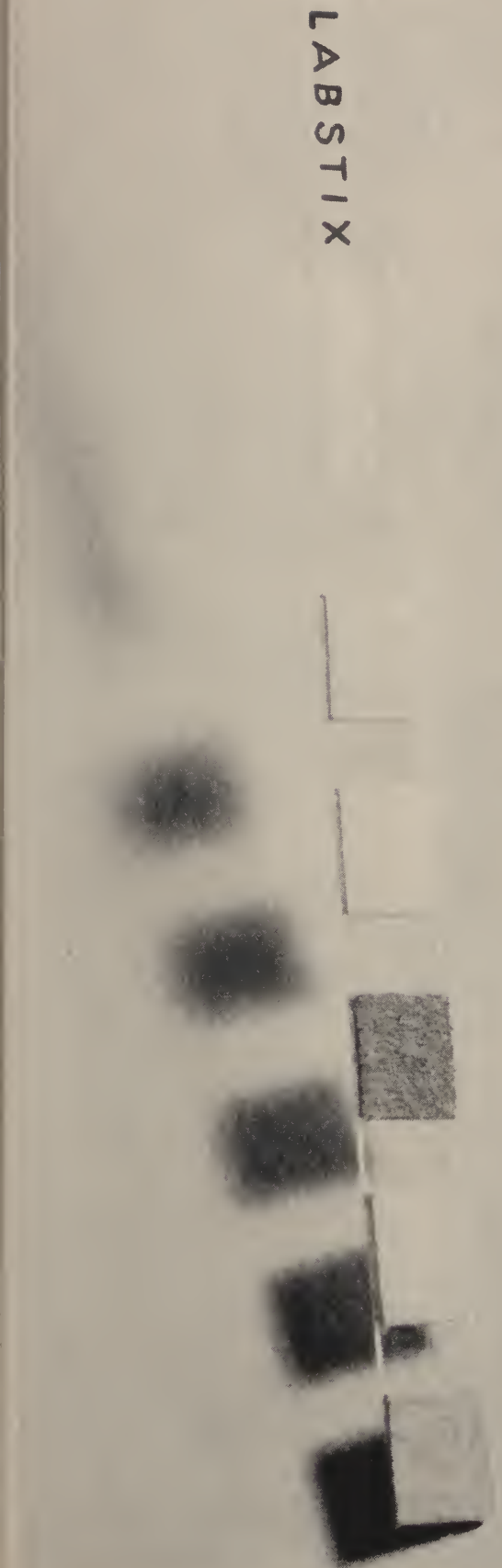
Mrs. Percy H. Sutley, president, has announced that the next luncheon meeting of the Auxiliary will be in Osler Hall on Wednesday, February 8, at noon, and that the speaker will be Mr. Charles Moylan, Jr., State's Attorney. His topic will be "Crime on our City Streets."

Following Mr. Moylan's talk, there will be a business meeting at which a committee to nominate a slate of officers will be elected.

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References: 1. Pillsbury, D. M., Shelley, W. B., and Kligman, A. M.: A manual of cutaneous medicine, Philadelphia, Saunders, 1961, p. 79. **2.** Barber, M., and Garrod, L. P.: Antibiotic and chemotherapy, Baltimore, Williams and Wilkins, 1963, p. 111.



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Richard Norment, III, MD—1967
J. Arthur Weinberg, MD—1967
J. Emmett Queen, MD—1968
Donald Roop, MD—1968
Harry M. Robinson, Jr., MD—1968
Robert C. Kimberly, MD—1969

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Robert W. Farr, MD—1967
Raymond M. Yow, MD—1968

Southern District
Arthur Wooddy, MD—1968
Manning W. Alden, MD—1969

South Central District
Henry P. Laughlin, MD—1967
William B. Hagan, MD—1969

Terms of office expire at conclusion of annual meeting

DELEGATES TO THE
AMERICAN MEDICAL ASSOCIATION
Russell S. Fisher, MD—1966
J. Sheldon Eastland, MD—1967
Robert vL. Campbell, MD—1968

ALTERNATES:
E. I. Baumgartner, MD—1966
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Contraindications: Patients with known hypersensitivity to the drug.

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Precautions: In elderly and debilitated and in children over five, limit dosage to smallest effective amount, increasing gradually as needed and tolerated. In general, concomitant use with other psychotropics is not recommended. Paradoxical reactions have been reported in psychiatric patients and hyperactive aggressive children. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically. Observe usual precautions in presence of impaired renal or hepatic function, impending depression and suicidal tendencies.

Adverse reactions: Drowsiness, ataxia and confusion may occur, especially in elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. Syncope occurs rarely. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis, jaundice and hepatic dysfunction) may develop occasionally, making periodic blood counts and liver-function tests advisable during protracted therapy. Individual maintenance dosages should be determined.

Dosage: Oral—Adults: Mild to moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d.

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Maryland
STATE MEDICAL JOURNAL



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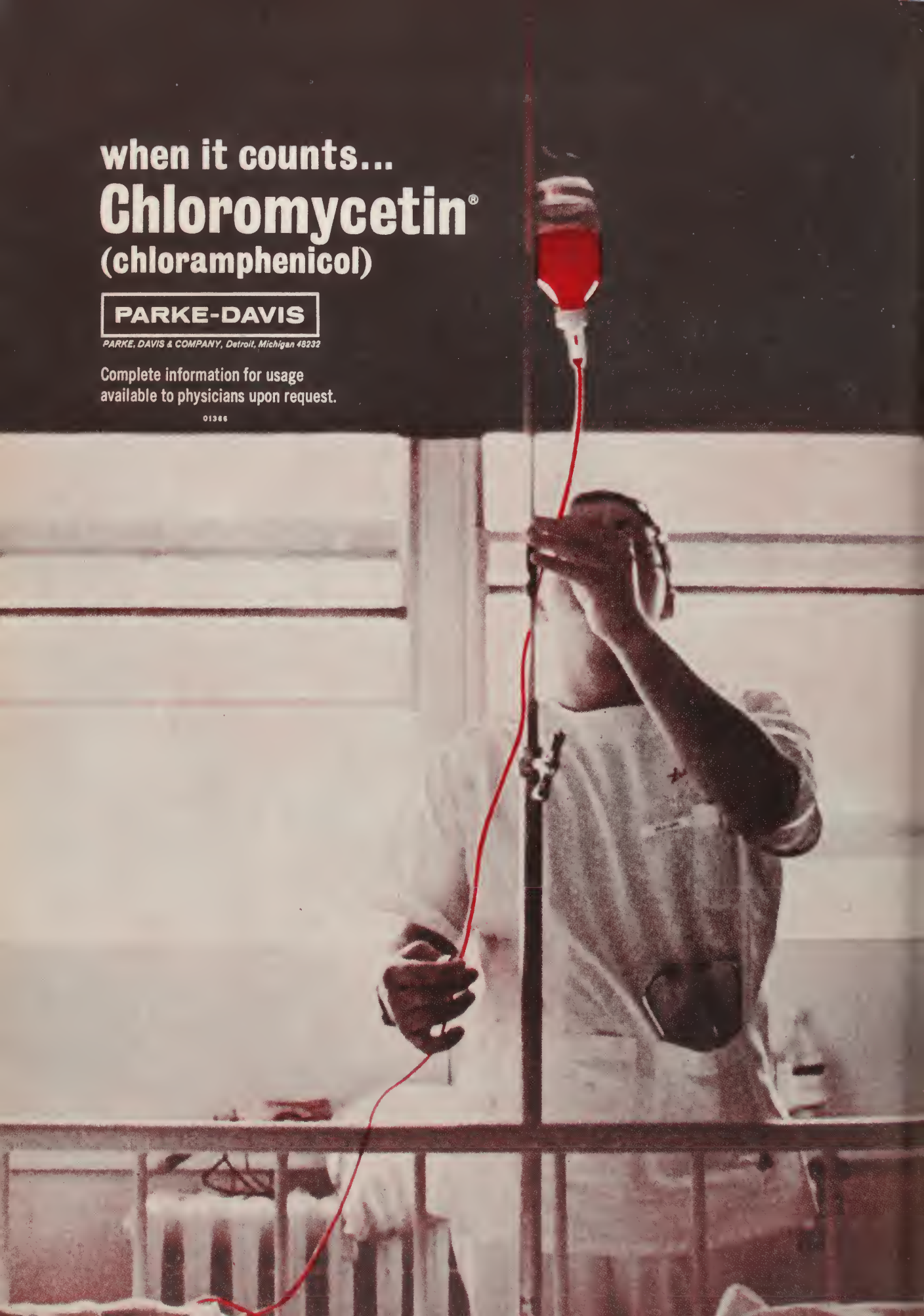
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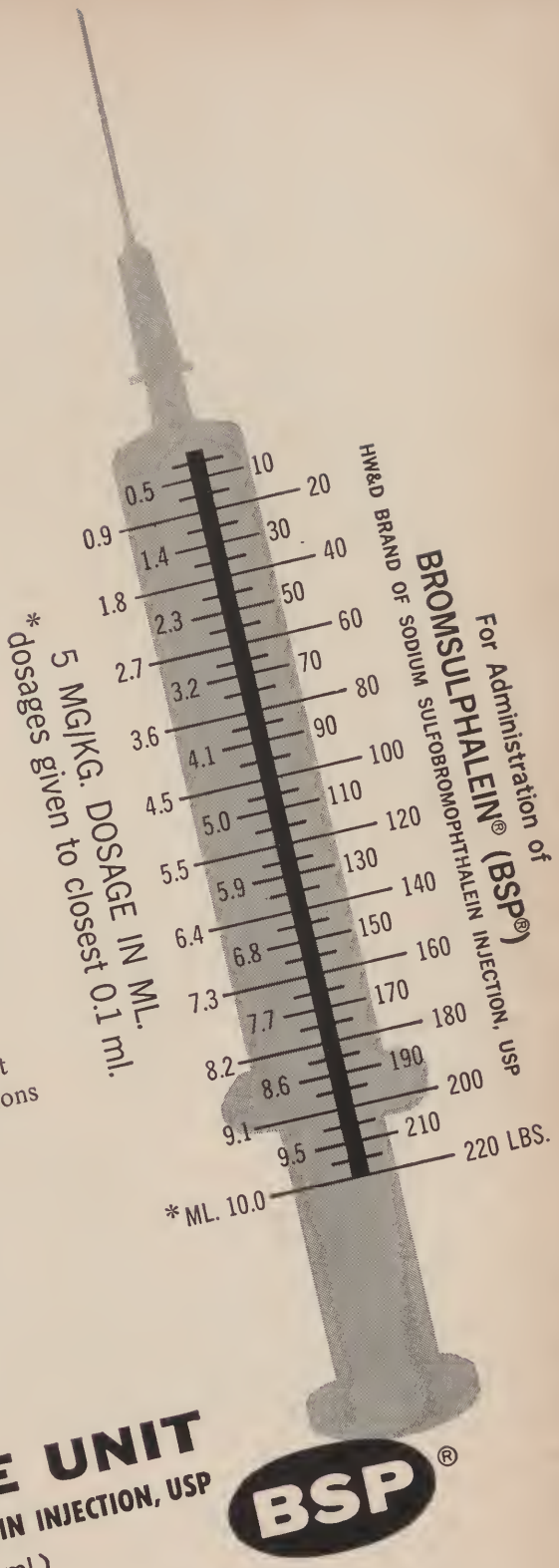
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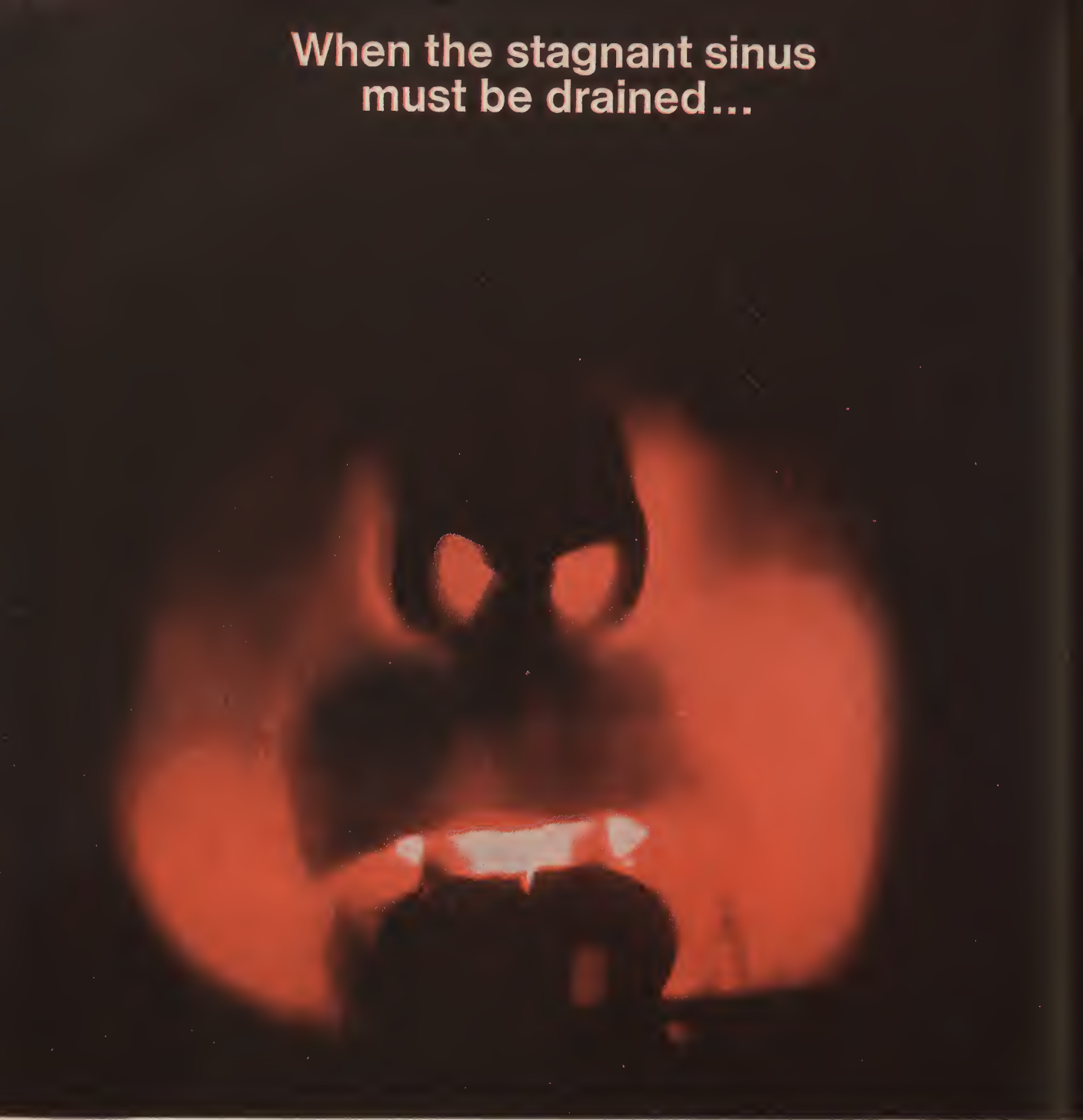
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February, 1967

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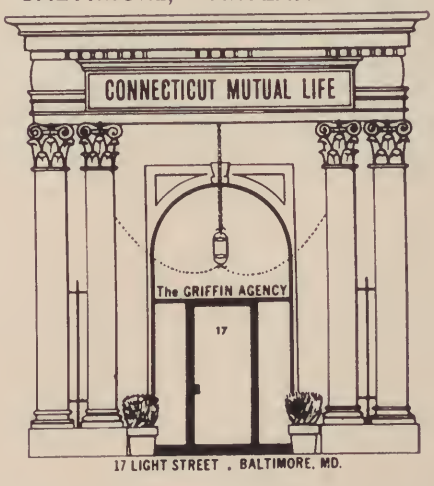
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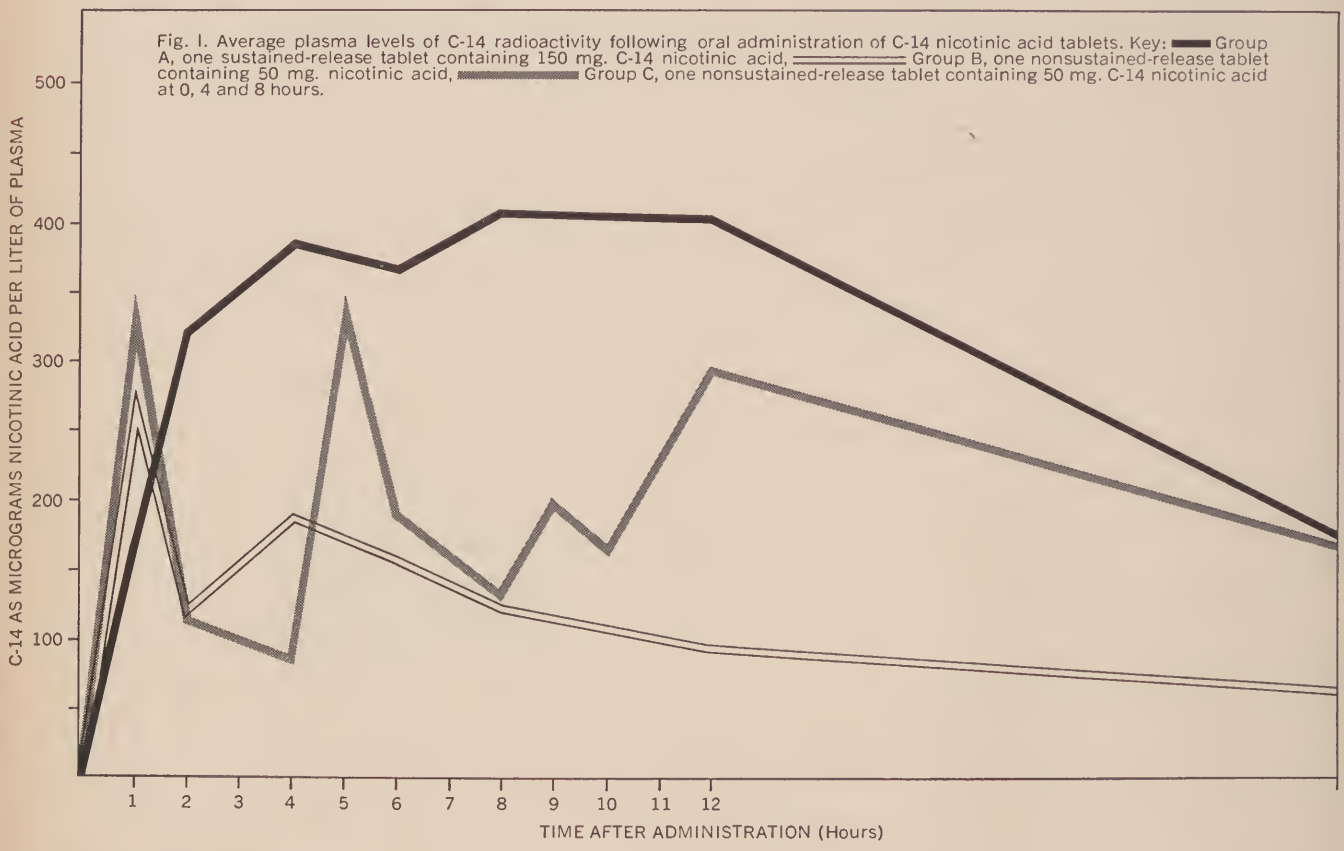
State of Maryland Department of Mental Hygiene

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Sustained circulatory, respiratory and cerebral stimulation for the





(fewer absent doses by absent-minded patients)

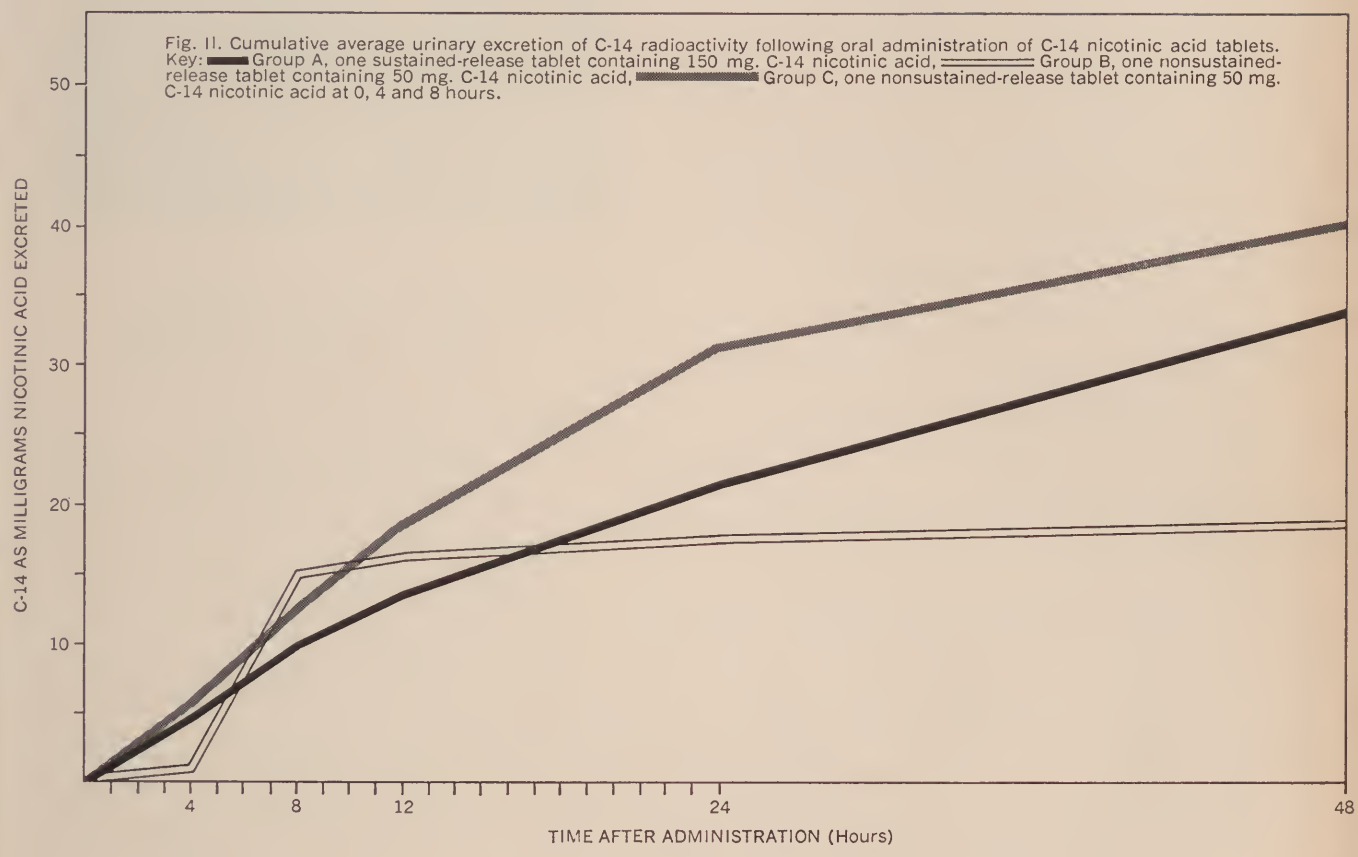
Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

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Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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Smith Kline & French Laboratories and Hynson, Westcott & Dunning, Inc., are making a contribution, although they are unable to have exhibits this year.



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MEDIC

FRIDAY POSTGRADUATE PROGRAMS

See page 145 for list of locations where MEDIC progroms may be heard)

March 3, 12:30 PM

Anesthesiology-Respiratory Problems of the Asthmatic

Martin I. Gold, MD, associate professor of onesthesiology, University of Moryland School of Medicine.

March 10, 12:30 PM

Hypersusceptibility to Infection: Evaluation and Management

F. Robert Fekety, Jr., MD, ossistant professor of medicine, the Johns Hopkins University School of Medicine.

March 17, 12:30 PM

The Use of Physical Medical Techniques in the Management of Arthritis

B. Stanley Cohen, MD, head, Department of Physical Medicine and Rehabilitation, Sinoi Hospital of Baltimore.

March 24, 1:00 PM

Parathyroid Disease

Commander Jonas Sode, MC, Medical Service, US Navol Hospital, Bethesdo.

March 31, 12:30 PM

The Effective Use of a Pathology Service

Thomos M. Peery, MD, Professor of Pathology ond Director Loborotory Service, George Washington University Medical School.

GRAND ROUNDS VIA MEDIC

(The following progroms may be heard ot network hospitols only.)

Tuesday, February 21, 28; March 7, 14
11:30 AM-1:00 PM—MEDICAL GRAND ROUNDS
from University Hospitol

Friday, February 17, 24; March 13, 20
2:00 PM-3:00 PM—NEUROLOGY GRAND ROUNDS
from University Hospitol

Saturday, February 18, 25; March 4, 11
8:00 AM-9:00 AM—PEDIATRIC GRAND ROUNDS
10:00 AM-11:30 AM—MEDICAL GRAND ROUNDS
from the Johns Hopkins Hospitol

JOINT ANESTHESIA STUDY COMMITTEE

of the Baltimore City Medical Society and the Baltimore City Health Department.

February 28, 7:30 PM

March 28, 7:30 PM

1211 Cathedral Street, Baltimore

BALTIMORE CITY MEDICAL SOCIETY

March 3, 8:30 PM

Comprehensive Care of the Cancer Patient in a Community Teaching Hospital

John H. Tuohy, MD, medical director, Saint Agnes Hospital; clinical assistant professor of medicine, Georgetown University School of Medicine.

Program Provisions for Regional Medical Centers for Heart Disease, Cancer and Stroke under Public Law 89-239

Leonord Scherlis, MD, member of Advisory Committee for Marylond's Program.

Question and Answer Period

1211 Cathedral Street, Baltimore

MARYLAND ACADEMY OF GENERAL PRACTICE

March 5, 11:00 AM

Board of Directors Meeting

Holiday Inn, Baltimore

May 20-21

Annual Spring Meeting

Washington Motel, Gaithersburg, Md

Theme: Troumo

Election of Officers

For informotion, write: G. O. Himmelwright, MD (president, MAGP), 133 Virginio Ave., Cumberland, Md.

MEDICINE 1967

Sunday afternoons at 2:00 PM

WMAR-TV (Channel 2)

February 26

Medical Panel

(Questions and Answers)

Arranged By
HARRIS LOVICE, MD

March 5

Menopause

Arranged by
Harris Lovice, MD

March 12

Hospital Costs

Arranged by
Edwin H. Stewart, Jr., MD

March 19

Value of Autopsy

Arranged by
Anthony A. Lewandowski, MD

March 26

Pharmacy, A Sister Profession

Arranged by
Emmanuel A. Schimunek, MD

April 2

Sex and Marriage

Arranged by
William Schuman, MD

Sponsored by the

Committee on Public Medical Education and Public Relations

BALTIMORE CITY MEDICAL SOCIETY

William Schuman, MD, chairman

SECTION ON INTERNAL MEDICINE

March 27, 8:30 PM

Beta Adrenergic Receptor Blocking Drugs: Mechanism of Action and Clinical Applications (Illustrated).

Stephen E. Epstein, MD, senior investigator, attending physician, Natianal Heart Institute, National Institutes of Health, Bethesda, Md.

1211 Cathedral Street, Baltimore

MARYLAND DERMATOLOGICAL SOCIETY

March 2, 6:00 PM

Penn Hotel, Towson, Md.

Speaker: George Hambrick, MD, assaciate professor of dermatology, the Johns Hopkins University School of Medicine.

Subject: Ta be announced.

MARYLAND PSYCHIATRIC SOCIETY AND THE MARYLAND ASSOCIATION OF PRIVATE PRACTICING PSYCHIATRISTS

March 9, 8:30 PM

Wendell Muncie Award-winning Paper

1211 Cathedral Street, Baltimore

MARYLAND PEDIATRIC SOCIETY

March 14, 8:00 PM

House Officers' Night

1211 Cathedral Street, Baltimore

PATHOLOGY SECTION

March 20, 8:00 PM

Case Presentation

Hemoglobin Abnormalities Found at the Medical Examiner's Office.

CHARLES PETTY, MD

CLINICAL PSYCHIATRY FOR THE PRACTICING PHYSICIAN

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March 28, 7:30 PM-9:30 PM

Georgetown University Hospital

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For information, write: Louis F. Rittelmeyer, Jr., MD, Geargetawn University Hospital, 3800 Reservoir Road, N.W., Washington, D.C. 20007.

CLINICAL APPLICATIONS OF ADVANCES IN CANCER RESEARCH

March 11

A one-day seminar presented by the Georgetown University Medical Center (sponsored by the District of Columbia Division of the American Cancer Society)

A registration fee of $5.00 includes luncheon and an afternoon reception.

Georgetown University Medical Center

For information, write: Division of Oncologic Surgery, Department of Surgery, Georgetown University Medical School, Washington, D.C. 20007.

AMERICAN ORTHOPSYCHIATRIC ASSOCIATION

March 20-23

44th Annual Meeting—Washington, DC

Theme: The Impact of Schools in Human Development—A Critical Appraisal of a Social Institution

March 27-29

Post-conference Meeting—Kingston, Jamaica

Theme: Impact of Education on Human Development

For information, write: William Stark, MD, 5415 Connecticut Ave., NW, Washington, DC 20001.

PUBLICATIONS AVAILABLE ON REQUEST

From the National Library of Medicine of the US Public Health Service (write to the Assistant to the Director, 8600 Rockville Pike, Bethesda, Md. 20014): Two pilot issues of a proposed monthly *Bibliography of Medical Reviews*.

From the American Medical Association (write the Program Services Department, 535 North Dearborn St., Chicago, Ill. 60610): *Horizons Unlimited* (144-page paperback) and other literature and materials related to careers in medicine and allied fields.

From the American Heart Association (write the AHA at 44 East 23rd St., New York, N.Y. 10010): *Hypertension—Neurohumoral Mechanisms and Vascular Smooth Muscle*, a presentation of 15 articles from the 1965 scientific sessions of the AHA Council for High Blood Pressure Research; *Drug Treatment of Arterial Hypertension*, a booklet intended as a reference for physicians in office treatment of hypertensive patients; *Symposium on Congestive Heart Failure*, an updated monograph of a publication originally issued five years ago; and *Your 1000 mg Sodium Diet*, a leaflet for patients based on the booklet of the same name for physicians.

AMERICAN COLLEGE OF SURGEONS

March 11-13

Sectional Meeting for Doctors and Nurses

Williamsburg, Va

For information, write: Communications Division, American College of Surgeons, 55 East Erie St., Chicago, Ill. 60611.

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The following courses are made possible by the generous cooperation of the directors and institutions involved. Tuition fees: Members, $60.00; Nonmembers, $100. Registration forms and requests for information are to be directed to: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104

MARCH 6-10

Recent Advances in Cardiovascular Disease

The Mount Sinai Medical Center, New York, NY; Charles K. Friedberg, MD, FACP, director.

MARCH 13-17

Physiological Aspects of Cardiopulmonary Disease

Yale University—New Haven Medical Center, New Haven, Conn; Frank D. Gray, MD, FACP director; Donald F. Egan, MD, co-director.

MARCH 20-24

Fundamental Concepts of Gastroenterology

University of Michigan Medical Center, Ann Arbor, Mich; H. M. Pollard, MD, FACP, director.

MARCH 27-31

Psychiatry for the Internist

Wayne State University School of Medicine (Lafayette Clinic), Detroit, Mich; Paul Lawinger, MD, director; Victor Bloom, MD, co-director.

MAY 8-12

CLINICAL AUSCULTATION OF THE HEART

Georgetown University School of Medicine and Georgetown University Hospital, Washington, DC; W. Proctor Harvey, MD, FACP director.

MAY 15-19

RECENT ADVANCES IN CLINICAL ENDOCRINOLOGY

University of Washington, Seattle, Wash; Robert H. Williams, MD, FACP, director; Neil J. Elgee, MD, FACP, and Francis C. Wood, Jr., MD, co-directors.

AMERICAN MEDICAL ASSOCIATION COUNCIL ON RURAL HEALTH

March 10-11

20th National Conference

Charlotte, NC

For information, write: Council on Rurol Heolth, AMA, 535 North Deorborn St., Chicago, Ill. 60610.

MARYLAND OPHTHALMOLOGICAL SOCIETY

March 30

Cocktails 6:00 PM, Dinner 7:00 PM, Speaker 8:00 PM

Trends in Cataract Surgery

R. M. Fosanella, MD, New Haven, Conn.

Sheraton-Belvedere Hotel, Baltimore

IMMUNOLOGIC APPROACHES TO MECHANISMS OF CUTANEOUS DISEASE

March 29-31

A symposium sponsored by the Departments of Dermatology and Medicine, New York University Medical Center

For information, write: Office of the Recorder, New York University Post-Graduate Medical School, New York, N.Y. 10016.

FORTIETH ANNUAL SPRING CONGRESS IN OPHTHALMOLOGY AND OTOLARYNGOLOGY

April 3-7

Gill Memorial Eye, Ear, Nose and Throat Hospital and Clinic

Roanoke, Virginia

For information, write: Superintendent, P.O. Box 1789, Roanoke, Vo.

AMERICAN ACADEMY OF PEDIATRICS

April 3-5

Annual Spring Session

San Francisco Hilton Hotel

April 3-4

St. Francis Hotel, San Francisco

Co-sponsored by the California Nurses Association

For information, write: AAP, 1801 Hinman Ave., Evanston, Ill. 60204.

AMERICAN HEART ASSOCIATION

CARDIOLOGY POSTGRADUATE COURSES

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April 6-8
Psychosomatic Aspects of Cardiovascular Disease
Oklahoma City

May 8-12
Cardiology Today
Atlanta

September 18-20
Congenital Heart Disease Problems
Boston

November 30-December 3
Electrocardiographic Diagnosis of Arrhythmias
St. Petersburg

Registration fee: Members and Fellows of Council on Clinical Cardiology, $50
Non-members, $85

For information, write: Director of Medical Education, American Heart Association, 44 East 23rd St., N.Y., N.Y. 10010.

PHILADELPHIA COUNTY MEDICAL SOCIETY

April 11-14

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1967 AMERICAN INDUSTRIAL HEALTH CONFERENCE

April 10-13

Americana Hotel, New York City

Sponsored by the Industrial Medical Association and the American Association of Industrial Nurses

For information, write: American Industrial Health Conference, 55 East Washington St., Chicago, Ill. 60602.

TENTH ANNUAL JOINT CARDIAC SYMPOSIUM

April 27

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NATIONAL SOCIETY FOR THE PREVENTION OF BLINDNESS

April 12-14

Annual Conference—Columbus, Ohio

Theme: Setting Sights for Sight Saving

For information, write: John D. Colemon, Director of Information, National Society for the Prevention of Blindness, Inc., 16 East 40th St., New York, N.Y. 10016.

AMERICAN CANCER SOCIETY

May 3

1967 Scientific Session

Theme: Current Concepts in Etiology and Diagnosis of Cancer

Open to all members of the medical profession and to all medical students—no registration fee

Sheraton-Dallas Hotel, Dallas

THREE-STATE CONFERENCE ON AIR RESOURCE MANAGEMENT

May 15-16

City College New York, NY

The first attempt to develop a blueprint for community action against air pollution on an interstate basis, the conference will focus on the New York-New Jersey-Connecticut metropolitan complex. The three state health commissioners are among the members of the Conference Board, of which Norman Cousins is chairman.

For information, write: Prof. Richard G. Coulter (conference coordinator), Department of Engineering, The City College, 138th St. and Convent Ave., New York, N.Y. 10031

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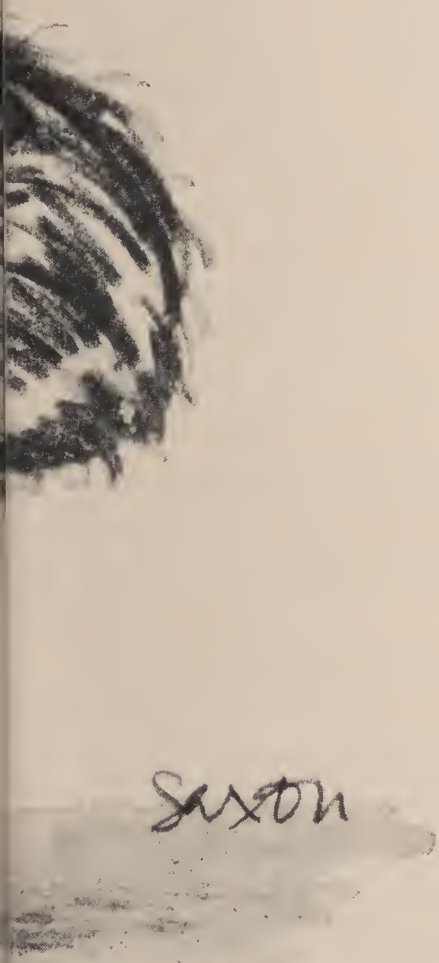
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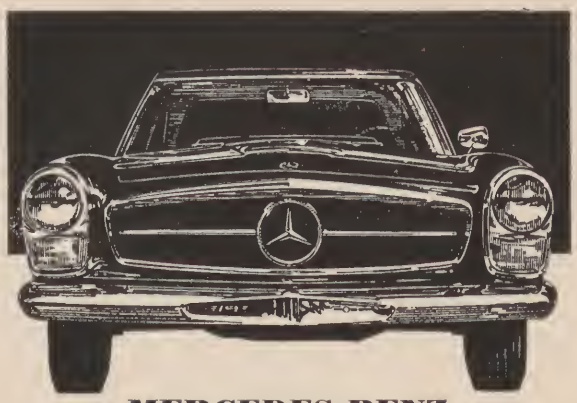
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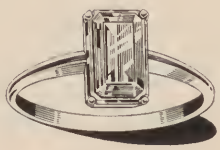
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EXECUTIVE SECRETARY'S NEWSLETTER

February, 1967

ANNUAL MEETING RESOLUTIONS

The following resolutions have been introduced for consideration at the Annual Meeting, Friday, April 21, 1967:

1A/67 - by Prince George's County Medical Society. "Condemning Attempts by Insurance Carriers to Determine Qualifications of Physicians; and Requesting that such Carriers Amend Their Regulations to Prevent This"

2A/67 - by M. B. Levin, M.D., Baltimore City "Providing for Changes in the Medical Practice Act"

3A/67 - by George Vash, M.D., Baltimore City "Closing of All Well-Baby Clinics and Transfer of Patients to Private Physicians"

All will be discussed at the Reference Committee Meeting scheduled for:

Wednesday, March 29, at 8:00 p.m.

at the Faculty Building. All members and interested parties are welcome to present their views.

Copies of the resolutions are available to Faculty members through the Faculty office.

GENERAL MEETING RE MILLIS REPORT ON INSURANCE FORMS

A General Meeting to which all interested persons are invited has been scheduled by the Liaison Committee. Its purpose is to discuss all insurance and other forms utilized by physicians.

The Millis Report deals with the new curriculum proposed for education of physicians and, more specifically, to increase the supply of Personal Physicians.

The meeting is to be held in the Faculty Building on Thursday, March 23, at 8:00 p.m.

GOOD SAMARITAN PLANNING OFFICE

Physicians interested in contacting those responsible for the planning of the Good Samaritan Hospital may make contact with them at:

Good Samaritan Planning Office,
1650 East Belvedere Avenue, Apt. T3
Baltimore, Maryland 21212
Telephone: 323-1800 or 323-1801

All communications should be addressed, Care of the Medical Director.

NEWS NOTES

David B. McIntyre, M.D., and James Castellano, M.D., have moved their offices to 3350 Wilkins Avenue where they practice Obstetrics and Gynecology.

Harris Lovice, M.D., has opened his office for the practice of Internal Medicine and Endocrinology at the Pikesville Medical Center.

Leonard J. Gallant, M D., is scheduled to present a seminar on the Psychotherapy of the Socially Disturbed at Guys Hospital, London, England, in April.

Jonas R. Rappeport, M.D., has been named to the Board of the Patuxent Institute for the Criminally Insane.

New Medical Staff appointments include, E. Paul Coffay, Jr., M.D., as President of St. Joseph Hospital; George H. Greenstein, M.D., at Sinai Hospital; and Irvin H. Cohen, M.D., as Director of Psychiatric Education.

Donald A. Wolfel, M.D., Baltimore, has been made a Fellow of the American College of Radiology.

John Sargeant

Executive Secretary

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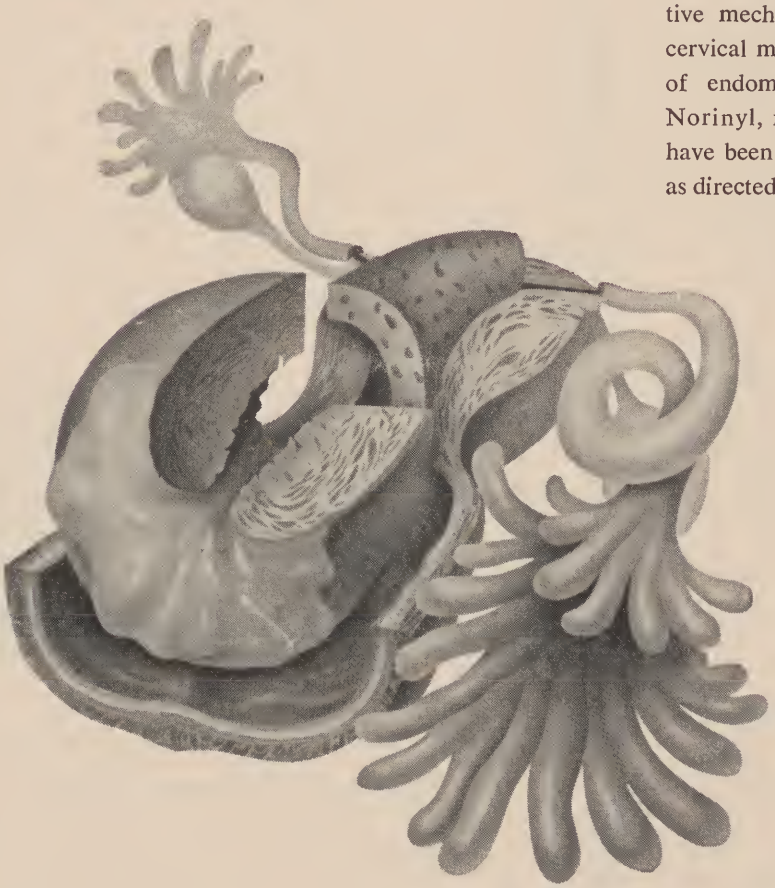
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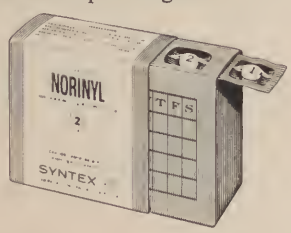
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Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism.

Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: 1. Council on Drugs. JAMA 187:664 (Feb. 29) 1964. 2. Bryans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. 3. Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. 4. Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. 5. Hammond, D. O.: Ibid. 6. Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. 7. Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. 8. Kempers, R. D.: GP 29:88 (Jan.) 1964. 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10. Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. 11. Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

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EXECUTIVE COMMITTEE, JANUARY 5

1. Acting upon a request from the Student American Medical Association that the Faculty become a "sustaining" member of SAMA at an annual cost of $100, the Committee voted in favor of membership.

2. The requests of the chairmen of two Faculty Committees for funds to attend February meetings in Chicago were discussed at length. One, a request for transportation expenses only, was granted on the dual basis that the meeting would provide indoctrination for a new chairman and the program, designed to explore activities at state and county levels, would assist him in the guidance of Committee activities during the coming year; the other, a request for general expenses, was denied on the grounds that the chairman had attended previous meetings on the same subject and the benefits to him and to his committee of his attendance at another did not appear to warrant the expenditure of Faculty funds.

3. The installation, for security reasons, of an electric door-opener on the front, inside door of the Faculty building was approved. The estimated cost is $225.

4. The Committee selected Charles J. Savarese, MD, chairman of the Faculty's Medical Emergency Disaster Committee, to attend an American Medical Association Meeting on Emergency Medical Services in Chicago, on April 6 and 7, at AMA expense.

5. Karl F. Mech, MD, reported that the last surviving beneficiary of the Walter R. Steiner Trust Fund had died and that the corpus now comes to the Faculty. On June 30, 1966, the market value of the fund, the income from which is to be used for books and journals, was approximately $381,000.

6. It was determined that Emeritus membership in the Faculty for Henry G. Hadley, MD, could not be granted at his request since the Bylaws require that such membership be considered only on the recommendation of a Component Society. Although Dr. Hadley qualifies for Emeritus membership in other respects, he is not at present a member of any Component Society; having retired, he is not eligible for membership in Prince George's County, where he resides, and the Anne Arundel County Medical Society, of which he was formerly a member, does not feel it can recommend him because he is no longer practicing or residing in that county.

7. The Committee denied a request from the publishers of *Encyclopaedia Britannica* to use the Faculty letterhead to solicit Faculty members by mail in return for ten dollars per member-sale.

8. The Committee approved of the President's recommending the following pediatricians to the State Board of Health and Mental Hygiene for appointment to the Advisory Council on Mental Hygiene: Annie M. Bestebreurtje, MD, of Baltimore City; John M. Krager, MD, and Ramsay B. Thomas, MD, both of Baltimore County. Recommendation to the same Board of Donald M. Roop, MD, as Health Officer for Baltimore County, was

also approved.

9. A letter to Governor-elect Agnew was authorized in connection with the reappointment to the State Board of Health and Mental Hygiene of Aaron Dietz, MD; Irene M. Duffy, RN; and Cornelius P. Kruse, PhD.

10. The Committee approved of the listing of the following three names for consideration by the Governor in the appointment of a physician trained in roentgenology, and in practice for five years, as a member of the Medical Board for Occupational Diseases for a six-year term: Whitmer B. Firor, MD (reappointment); John M. Dennis, MD; and Byron G. Brogdon, MD. Others presently serving on this board are J. Sheldon Eastland, MD, and James Frenkil, MD.

11. Having examined information obtained relevant to an anonymous accusation that compulsory assessment of medical staff members exists at St. Joseph Hospital and Maryland General Hospital, the Committee concluded that there seemed to be no compulsion with regard to assessments, but decided to advise the Judicial Council of the AMA of this opinion and to ask for comments on the specific situations involved.

12. Based on the information available in the case of a complaint from M. B. Levin, MD, against the Greater Baltimore Medical Center, the Committee agreed that the patient had the right of free choice as to his institution and his physician and that Dr. Levin should be advised of its conclusion that the actions of GBMC were in order.

13. It was reported that the Maryland Hospital Commission had given its assurance that in making its determinations on applications for loan funds, the Commission would refer to all available, appropriate sources of information.

14. The Committee agreed that correspondence involving complaints about the medical care program should be referred to the Faculty's representatives on the Council on Medical Care for their information and action.

15. The Committee concurred in action taken by the Executive Secretary in registering an objection with the State Department of Health to a regulation that would require examinations at proposed Group Day Care Centers by "qualified pediatricians" rather than by "physicians." It was agreed that designation by specialty indicated discrimination against other physicians.

16. The Committee agreed to obtain, in writing, the policies to be established in connection with staff privileges at the new Good Samaritan Hospital.

17. A "correspondence blitz" on US Senators and Congressmen with respect to "direct billing" for medicare patients (Public Law 89-97, Title 19) was reported to have been recommended by the Lousiana State Medical Society and was discussed at length. The Committee questioned the extent of knowledge among physicians of the direct billing regulations and the value of the suggested approach, but agreed that members individually could be urged to protest the regulations through any available means.

COUNCIL, JANUARY 19

1. The Council endorsed the proposal of a request for a grant from the US Public Health Service for a Model Ambulatory Community Health Service for Chronic Respiratory Disease at the Maryland General Hospital, as presented and explained by William S. Spicer, Jr., MD, who is in charge of the project.

2. Speaking for John Whitridge, Jr., MD, chairman of the Subcommittee on Maternal Welfare, John H. Hirschfeld, MD, chairman of the parent Committee on Postgraduate Education, Preventive Medicine and Public Health, presented the proposal that the Faculty endorse a policy on family planning similar to that of the AMA. By vote of the Council, the Medical and Chirurgical Faculty went on record as "recognizing the provision of family planning advice and services as an integral part of the practice of medicine" and as urging "the physicians of Maryland to provide such advice and services as are consistent with their own personal and moral convictions and those of their patients."

3. As recommended by Milton B. Kress, MD, chairman of the Subcommittee on Chronic Respiratory Diseases, the Council voted to direct the Legislative Committee and the Legislative Representative of the Faculty to remain alert for an opportunity to propose an amendment to the law regulating the Air Pollution Control Council to

the effect that a "physician in active practice, skilled in the treatment of pulmonary disease" be included as a member of the Council.

4. On the recommendation of the Committee on Postgraduate Education, Preventive Medicine and Public Health, to which the proposal had been referred, the Council voted to take no action in connection with a request for a grant for study of the need in Maryland of a Regional Medical Center for Heart Disease, Cancer and Stroke under Public Law 89-239. It was the consensus that the proposed request did not need the Faculty's approval or disapproval.

5. Approval was granted for use of the MEDIC network by those responsible for implementation of the Educational program related to PL 89-239, with the understanding that appropriate charges would be made.

6. Having heard and discussed a proposal for a statewide measles immunization program to be financed by funds from the Faculty's Educational Fund, the Council voted for endorsement of such a program as a Component Society endeavor with the understanding that the Educational Fund may be used for publicity and educational purposes, but that the program would be implemented as each component saw fit.

7. On the recommendation of the Executive Committee, the Council unanimously approved the suggestion that payments under Maryland's Medical Assistance program be handled by Maryland Medical Service, Inc., because of its wide experience in this field and because of the savings that could be effected.

8. Ratification of legal defense for six physicians was approved.

9. Settlement of a case against a physician was reported.

10. As recommended by the Program and Arrangements Committee, April 1, 2 and 3 were approved as the dates for the 1970 Annual Meeting of the Faculty.

11. Advised that an additional sum of $1,500 had been received from M. McKendree Boyer, MD, for addition to the George M. Boyer, MD, Lecture Fund, the Council voted an expression of appreciation.

12. The recommendation of the Executive Committee that use of the Faculty building on a no-charge basis be restricted to Specialty groups 90% of whose members are Faculty members was adopted by a vote of nine to seven, it being understood that any group which does not fulfill this requirement may continue to use the facilities by paying the expenses involved. Specialty groups will be requested annually to check the conformity of their membership with the 90% requirement.

13. The Council, on recommendation of the Executive Committee, adopted the following policy for the Faculty: "Employment policies are based on the person's ability to perform the task involved and are not subject to discrimination upon the basis of race, color, religion, national origin or ancestry."

14. The Council approved the 1967 budget as presented by the Treasurer and as recommended by the Executive Committee.

15. Seven independent paragraphs in four articles of the Med-Chi Insurance Trust were amended as recommended by legal counsel and the Trustees.

16. The Council voted to nominate the following for three-year terms on the Blue Cross Board of Directors: William D. Lynn, MD, Baltimore City (reappointment); J. Tyler Baker, MD, Easton; and Richard A. Young, MD, Hagerstown.

17. Three physicians were nominated for three-year terms on the Blue Shield Board of Directors (F. Ford Loker, MD, a reappointment; J. Sheldon Eastland, MD, also a reappointment; and C. Parke Scarborough, MD—all of Baltimore City) and three (all reappointments and all of Baltimore City) for one-year terms as members of the Blue Shield Medical Relations Committee: Robert F. Healy, MD, surgeon; W. Bradley King, Jr., MD, pathologist; and Edward H. Richardson, MD, gynecologist.

18. The Council voted to nominate the following to serve for one year on the Blue Shield Reference and Appeals Committee: A. Talbot Brice, MD, general practice; Webster H. Brown, MD, radiology; W. Bowdoin Davis, Sr., MD, plastic surgery; Albert H. Dudley, Jr., MD, obstetrics and gynecology; William B. Holden, MD, psychiatry; J. T. H. Johnson, MD, orthopedics; Nicholas Mallis, MD, urology; B. Martin Middleton, MD, surgery; Granville H. Richards, Jr., MD, gen-



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eral practice; John E. Savage, MD, obstetrics; Harry M. Robinson, Jr., MD, dermatology; Wilfred H. Townshend, MD, internal medicine; and M. Elliott Randolph, MD, ophthalmology. All but Dr. Townshend and Dr. Randolph are reappointments; all but Dr. Brice, of Jefferson, and Dr. Richards, of Port Deposit, practice in Baltimore City.

19. The Council voted to reject the recommendations of the Mediation Committee proposing various amendments to the report of the Subcommittee on Laboratory Services that was originally adopted on June 17, 1965, and to submit the matter to the Mediation Committee and representatives of the Maryland Society of Pathologists for discussion at a joint meeting.

20. On the recommendation of the Baltimore City Medical Society, the Council voted to recommend Emeritus membership for John L. Peck, MD, to the House of Delegates and, in accordance with Article III, Section 7 of the Faculty Bylaws, voted for remission of 1967 dues for Byruth Lenson-Lambros, MD, because of financial hardship.

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Three days of scientific sessions at the annual meeting of the Medical and Chirurgical Faculty will provide an excellent opportunity for postgraduate education, according to an announcement by **James B. Brooks, MD,** chairman of the Committee on Program and Arrangements. In addition to speakers named in earlier issues of THE JOURNAL, the following outstanding men of medicine will present papers during the three-day period from April 19 through April 21:



Dr. Lee

Philip R. Lee, MD, who will speak on April 20, is Assistant Secretary for Health and Scientific Affairs, US Department of Health, Education, and Welfare. The title of his talk will be **"Medical Care: The Next Decade in the Public-Private Partnership."** Dr. Lee was born in San Francisco and received his AB and MD degrees from Stanford University. Following internship at Massachusetts Memorial Hospital in Boston, he became assistant resident physician at Stanford University Hospital. In 1949, he volunteered for active duty in the US Navy, and served for two years as a lieutenant in the Medical Corps. Most of this time was spent on active sea duty and included one year in the Korean theater.

After military service, Dr. Lee served first as a Fellow at Bellevue Medical Center, then as a Fellow at the Mayo Clinic in Rochester. While in Rochester he earned an MS degree at the University of Minnesota Graduate School. There followed a year of teaching and research at Bellevue Medical Center, after which Dr. Lee returned to his native California as a staff member of the Palo Alto Medical Clinic and assistant clinical professor at the Stanford University School of Medicine. From 1963 to 1965, he was director of Health Services in the Agency for International Development, Office of Technical Cooperation and Research. In May of 1965 he was given AID's Superior Honor Award and cited for establishing "new policies, priorities, and programs in the fields of health, nutrition, and population."

After serving as Deputy Assistant Secretary of Health, Education, and Welfare for a few months in 1965, he was appointed to his present position as Assistant Secretary for Health and Scientific Affairs. Dr. Lee is the author of numerous scientific articles and has contributed to many textbooks.

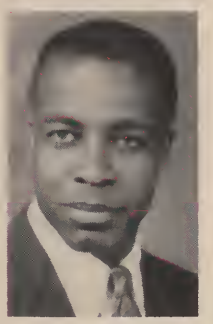


Dr. Palmer

Richard E. Palmer, MD, associate clinical professor of pathology at the George Washington University School of Medicine, will give the George M. Boyer, MD, Lecture this year. After receiving his MD degree from the George Washington University, Dr. Palmer served an internship and residency at the George Washington University Hospital, then served for a year as a teaching Fellow in pathology at the School of Medicine. Since 1949 he has been a pathologist at the Alexandria Hospital in Virginia and pathologist to the Office of the Chief Medical Examiner of Virginia.

Dr. Palmer has served as secretary and president of the medical staff of the Alexandria Hospital, president of the Alexandria Medical Society, president of the American Society of Clinical Pathologists, and president of the Medical Society of Virginia. Since 1962 he has been a trustee of the Private Practitioners of Pathology Foundation and was elected president for 1966-1967. Since 1965 he has been a commissioner representing the AMA on the Joint Commission on Accreditation of Hospitals. Dr. Palmer has had many articles published in national and state medical journals.

MEDICAL AND CHIRURGICAL FACULTY



Dr. Henry

Walter Lester Henry, MD, will present a paper on **"Differential Diagnosis of Hypercalcemia."** Dr. Henry is head of the Department of Medicine at Howard University College of Medicine and chief of medicine at Freedmen's Hospital in Washington, DC. Dr. Henry received his AB from Temple University and his MD from Howard University in 1941, graduating first in his class. After internship and residencies at Freedmen's Hospital in Washington, he attended the Graduate School of Medicine, University of Pennsylvania. From 1951 to 1953 he was a Fellow in Endocrinology at the Michael Reese Hospital in Chicago.

Dr. Henry is consultant in internal medicine at the Mt. Alto Veterans Administration Hospital and is visiting physician at the DC General Hospital. His membership in scientific and medical societies includes the American College of Physicians, the American Medical Association, the DC Medical Society, the National Medical Association, the Medico-Chirurgical Society of DC, and the Association of Federation for Clinical Research. Dr. Henry is the author of many scientific articles and in 1952 was certified by the American Board of Internal Medicine.



Dr. Gombos

Ervin A. Gombos, MD, and **Joseph H. Holmes, MD,** will participate in a kidney symposium moderated by W. Gordon Walker, MD, associate professor of Medicine at The Johns Hopkins University School of Medicine.

Dr. Gombos will speak on **"Chronic Hemodialysis, Clinical Program and Technical Solutions."** Dr. Gombos received an AB degree from Zrinyi Gymnasium in Budapest, and an MD degree at the University of Zagreb School of Medicine in Yugoslavia. He served a rotating internship and assistant residency at the University Hospital in Zagreb, followed by a rotating internship at French Hospital in New York and assistant residency at Memorial Center, also in New York. Dr. Gombos was a Fellow in medicine and Visiting Research Fellow at Memorial Center and Sloan-Kettering Institute and, successively, a Research Fellow and a Postdoctorate Research Fellow in the Department of Medicine, New York University School of Medicine. He is a member of the American Federation for Clinical Research, the American Society for Artificial Internal Organs, the New York Academy of Sciences, the American Physiological Society, the American Medical Association, the European Dialysis and Transplant Association, and other professional societies.

Dr. Gombos has served on the Scientific Advisory Council of both the National Kidney Disease Foundation and the Washington Heart Association. He is associate professor of medicine at the George Washington University School of Medicine, and chief of the Nephrology Section and director of the Hemodialysis Center at the Veterans Administration Hospital in Washington. He has contributed numerous articles to both American and foreign publications.



Dr. Holmes

Joseph H. Holmes, MD, the second participant in the kidney symposium, will speak on **"The Role of the Internist or Family Physician in Renal Transplantation."** He is professor of medicine, head of the Division of Renal Disease and director of the School of Medical Technology at the University of Colorado Medical Center in Denver. Dr. Holmes was graduated from Amherst College and received his MD degree at Western Reserve University and a doctor of medical science degree at Columbia University. After a rotating internship at Emory University Hospital and a residency in internal medicine at the University Hospital in Baltimore under Maurice C. Pincoffs, MD, from 1935 to 1937 he was a Fellow in medical sciences at Columbia University. His teaching appointments have included those of instructor and assistant professor of physiology at Columbia University.

Dr. Holmes served as a captain in the US Air Force assigned to the School of Aviation Medicine in San Antonio. He is a member of 14 scientific societies and is the author of over 135 articles, which have been published in scientific journals throughout the world. Dr. Holmes is certified by both the American Board of Internal Medicine and the American Board of Pathology.

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From Chicago

The Vietnam conflict is presenting new problems in treating the wounds of war according to an article by three Army surgeons in the January 2 issue of the *Journal of the American Medical Association*. Major Norman M. Rich, Major Egon V. Johnson, and Lt. Col. Francis D. Dimond, Jr., of the US Army Medical Corps, report that new, high-velocity weapons are causing greater tissue damage than any previous small arms. On the other hand, improved medical care is cutting loss of life on the battlefield. Rapid helicopter evacuation, adequate blood replacement, antibiotics, established principles of war surgery, and modern operating room equipment have markedly lowered the proportion of Vietnam deaths due to wounds, as compared with those in earlier wars.

Weapons as new as the M-16 rifle and as old as the bow and arrow created the hundreds of kinds of wounds seen by the three surgeons at the Second Surgical Hospital in South Vietnam. Their report is on 1,196 patients treated at the hospital in the first five months of 1966, and particularly 521 missile wounds treated in that time. About half the missile wounds were from gunshots, and about half were due to fragments from grenades, mortars, artillery, mines, etc. There were 243 wounds from Punji sticks, an ancient, but dangerous weapon of the Viet Cong. A Punji is a sharpened stick with a fire-hardened, contaminated point. It is placed in the ground at an angle designed to puncture a soldier's foot.

"The Viet Cong have been ingenious in designing booby traps that utilize small-arms ammunition," the surgeons said. One wooden trap with a simple rubber-band mechanism and a small nail to act as detonator can fire a .50-caliber bullet or a shotgun shell when someone steps on the wire release. Another simple trap consists of two boards with three .45-caliber bullets imbedded in one of them. Approximately eight pounds of pressure will detonate these bullets when the boards are pushed together by an unsuspecting soldier's foot.

The American M-16 rifle is a very effective weapon, the surgeons point out. Its bullet's high velocity (3,250 feet per second) causes enormous tissue damage. The "tumbling effect" of the bullet after it strikes an object adds to this injury. The surgeons saw the effectiveness of the M-16 when some of these rifles fell into the hands of Communist forces and were fired at Americans, wounding several.

Only 1.3% of American soldiers wounded by missiles died after operations at the surgical hospital. This is a markedly lower figure than for similar operations in Korea and World War II. Wound infections after primary wound-closure operations totaled only 2%. Of those sustaining missile wounds, 58.1% were returned to duty after an average stay of 16 days in the hospital.

From an AMA news release, Jan. 1966.

From Washington

At a cost of nearly $1 billion, more than six million older persons got hospital care or medical benefits during the first six months of the medicare program.

Social Security Commissioner Robert M. Ball expressed satisfaction with the overall operations of the health insurance program for the elderly, but warned of bed shortages in the nation's capital, in various New England states, and in most rural areas as of January 1, when a new medicare benefit of nursing home care went into effect. He estimated that 50,000 to 60,000 beds would be needed for extended care in nursing homes.

The Commissioner's report on the first six months of medicare included the following items:

About 2.5 million elderly persons received free hospital care and 3.5 million benefited from medical services.

Since medicare began July 1, 1966, hospital occupancy has increased 5%, as expected. At the end of 1966, 30% of all hospital beds were occupied by those 65 or older.

About 6,700 hospitals are now participating

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in medicare. About 250 hospitals were excluded because they did not meet minimum standards. 75 because of racial discrimination.

Payments to doctors and skilled medical personnel, such as radiologists, have taken too long.

Overcrowding of hospitals occurred only in "isolated" instances.

The $3.00 premium payments were maintained by almost all of 17.5 million persons who signed up for additional medical insurance.

From an AMA news release, Jan, 1966.

From Bethesda

Blood cells from a chronic myelogenous leukemia (CML) patient have been grown, for the first time, in long-term culture by Public Health Service scientists at the National Cancer Institute, National Institutes of Health, Bethesda, Md.

Both the abnormal chromosome characteristic of CML and a type of virus particle frequently found in other human leukemia cells were observed in the new culture, according to two reports published in the December issue of the *Journal of the National Cancer Institute.*

For purposes of study, the cultured cells were grouped in three categories according to size. With the assistance of Dr. J. H. Tjio of the National Institute of Arthritis and Metabolic Diseases, the National Cancer Institute investigators carried out microscopic studies of the culture that revealed the genetic abnormality, known as the Philadelphia chromosome, in 23% of all cells. These abnormal cells were comparable in all respects to those usually found in bone marrow samples taken from patients with chronic myelogenous leukemia.

Electron microscope examination of special cell preparations revealed the presence of herpes-like virus particles in a significant number of cells in the medium size range. The particles appeared to be structurally identical to those found by other investigators in a culture of acute myelogenous leukemia cells and in several cultures of cells from patients with Burkitt's lymphoma, a type of cancer that occurs frequently in African children.

In addition, a pattern of intracellular changes

similar to those observed previously in other leukemia cultures was seen in the virus-containing cells of the new CML line.

According to the investigators, presence of the virus particles in the cells does not provide sufficient evidence of a causative relationship to leukemia. However, observation of similar virus particles and cell changes in both chronic and acute myelogenous leukemia lines suggests that the two leukemias are related and may be caused by viruses of the same family group.

Scientists taking part in the studies were Linda S. Lucas, Robert A. Manaker, and Victor H. Zeve of the Viral Biology Branch, National Cancer Institute; Jacqueline J. K. Whang, Medicine Branch, National Cancer Institute; and J. H. Tjio, Laboratory of Experimental Pathology, National Institute of Arthritis and Metabolic Diseases.

Public Health Service and National Cancer Institute news release, Jan. 1966.

From New York

Medicine and the law moved toward closer understanding and liaison in dealing with narcotics addicts at a national conference in New York City in January. Jointly sponsored by the American Medical Association, the Medical Society of the State of New York and the County Medical Societies of New York City, the conference featured a two-day workshop on the control of narcotics and the management of narcotic-dependent persons. Following are some of the highlights of the group discussions:

There may be a tendency on the part of some medical practitioners to avoid prescribing narcotics to their patients when indicated, rather than to become involved in the complexities of control. In some instances overlapping federal, state and local laws and regulations, and problems of confidential relations between patient and physician, make difficult the exchange of information necessary to define the extent of narcotic drug dependence and the need for treatment and rehabilitation resources and activities. Important progress was made at the conference on the solution of such problems.

It was recommended that medical advisory and liaison committees be established at the



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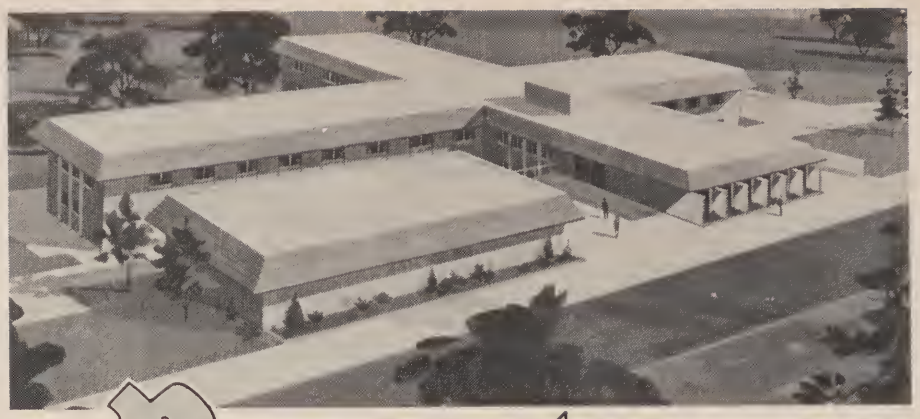
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state and county levels that could serve as a source of guidance to the individual practitioner, to the law enforcement agencies and to the general public.

Better training of medical students, interns and residents in treatment of narcotic-dependent persons was recommended. Few physicians ever see such patients during their training.

The American Medical Association and the National Academy of Sciences-National Research Council have established guidelines relative to the appropriate and ethical use of narcotics and the treatment of drug-dependent persons. These guidelines are utilized by the Federal Bureau of Narcotics in establishing relevant Bureau policies. Collaboration between national law enforcement agencies and organized medicine is quite good, but national cooperation is several steps ahead of that in several states and in many localities, pointing up the need for establishment of state and local liaison mechanisms.

From an AMA news release, Jan, 1966.

winter 1966

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this issue: the nose as a shock organ

the nose as a shock organ

by Charles J. Shagoury, M.D., Chelmsford, Massachusetts



"Is it a cold, hay fever, or has he been reprimanded by his boss?" Occasionally, you will ask yourself this question when confronted by a patient with abrupt onset of rhinorrhea, nasal obstruction, and sneezing. Usually the history will elucidate the problem, but examination of the nose will often provide valuable clues to the correct diagnosis.

The nose is a shock organ in a double sense. First, it is in the nose that the confrontation takes place with the surrounding atmosphere. For twenty-four hours a day, the nose must meet the varying challenges of the inspired air, containing perhaps noxious chemicals, dust, dirt, bacteria, viruses, fungi, and industrial pollutants of all kinds, and render it clean, virtually sterile, and fit for the sensitive alveoli of the lungs. Whatever the temperature or humidity of the atmosphere, the nose must transmit it to the lungs at approximately 98°F, and with a humidity of approximately 40%.[1]

Second, in particularly susceptible patients, the nose acts as a shock organ in a manner totally unrelated to its normal function. Persons with hay fever respond to ordinarily harmless materials by extreme nasal congestion, with marked rhinorrhea and violent spasms of sneezing. In some patients, exposure to threatening or disagreeable agents, or situations involving mental conflict may result in a reaction which is exclusively nasal, with swelling of the turbinates, and marked hypersecretion.[2]

Nasal symptoms usually result when the nose seeks to perform its function of getting rid of noxious and dangerous elements in the atmosphere, and prevent their admission to the trachea and lungs. Small particles are removed by the mucous coating which blankets the nasal passages. This mucous blanket contains a bacteriostatic agent, lysozyme, which destroys most air-borne bacteria.[3] The mucinous content renders the surface sticky, causing dusts and small particles to adhere. It has been postulated that this process is rendered more effective through adsorption because of a surface electrical charge on the nasal mucosa.[4] The cilia then sweep the particulate matter to the pharynx. The nose can prevent entrance into the lungs of particles as small as three microns in diameter, but smaller particles elude the nasal barrier. Most bacteria causing respiratory infections are one to three microns in diameter, but since they usually are inhaled in clumps, they are efficiently removed as a rule. Viruses, which are of the order of 1/1000 of this size, are less efficiently dealt with, unless they occur in very large aggregates.[5]

The nose will react in a more or less similar manner, whatever the nature of the offending agent, whether it be an irritant chemical, virus, pollen, or distasteful emotional situation. In acute coryza, the most characteristic sign is a profuse watery discharge. The volume of secretion may rise from practically nothing to nearly 60cc in twenty-four hours.[6] The mucous membrane is reddened and engorged, while the turbinates are markedly swollen. After the first day or two, the secretion becomes thicker, yellowish, and more difficult to expel. The surface cells are largely destroyed, contributing to the copious discharge, which now also contains numerous inflammatory cells which have migrated to the area. Gradually, over a period of a few days, or a week, the flood abates, the swelling and redness subside, and the nasal epithelium resumes a healthy appearance.

Repeated attacks of rhinitis, particularly if there is an underlying element of obstruction, may result in chronic rhinitis. The mucous membrane is constantly swollen and reddened. Sticky, mucopurulent secretions are a continuous feature, and the glandular elements are hypertrophied. Commonly, the mucosal surface takes on an irregular, rounded "mulberry" appearance, and nasal passages are occluded by the swollen turbinates and redundant mucosa.

While all of us are susceptible to colds, the victim of hay fever, or allergic rhinitis, displays a marked nasal reaction to materials in the air which leave his associates unaffected. In such a patient, the nasal mucosa has become an allergic "shock" organ. Contact with the nasal allergen causes local release of histamine, with vasodilatation, increased vascular permeability, and severe nasal congestion, similar to the "wheal" and "flare" reactions in the skin, when the epidermis is the allergic shock organ. While we eagerly await the coming of spring, the hay fever sufferer dreads the blooming season, whose invisible pollens are poisons to his sensitive nose. His neighbor's cat or dog may provoke paroxysms of uncontrollable sneezing. In some cases a specific allergen is not identified, but the triad of rhinorrhea, nasal obstruction, and sneezing is present.[7] The nose in these cases shows a pale, boggy, edematous mucosa, with a thin mucoid secretion. The mucous membrane shows extreme retractility to 1% cocaine or ephedrine. If the patient has medicated himself prior to examination, the nasal passages may appear abnormally patent, or show exaggerated congestion due to rebound reaction. The secretion may show a large number of eosinophils particularly after an attack of sneezing or rhinorrhea. Touching the mucosal surface, especially of the inferior turbinate, leaves an indentation, showing that the swelling is due to stasis and edema, rather than actual hyperplasia of the mucous membrane as in chronic hypertrophic rhinitis. Though the pale swollen mucosa is the hallmark of allergic rhinitis, as usually seen by the physician, exposure of allergic subjects to their known allergens results in a brief hyperemic phase, followed by pallor and edema.[8]

In the later stages of allergic rhinitis, the chronic edema of the mucous membrane results in the formation of polyps, clusters of grape-like masses hanging from the roof of the nose, with a pale glistening surface, contributing significantly to the sense of nasal obstruction and oppression.

A large group of patients show symptoms of nasal congestion when confronted by adverse life situations.[9] In these unfortunate persons, anxiety, frustration, and resentment are often accompanied by a runny nose and nasal obstruction. Lacrimation adds to the nasal stuffiness. This autonomic response, mediated by the parasympathetic nervous system, may be part of a general parasympathetic reaction, or may possibly represent in part, a symbolic effort to wash out and crowd out the offending situation.

Nasal congestion may also occur in some patients at times of sexual stimulation, and in women during menstruation and pregnancy, even to the point of epistaxis.[10] The relationship is obscure; castration results in atrophy of the nasal glands, and their action is inhibited by the hormones of the hypophysis and the thyroid.[11] The nose may be the shock organ in drug therapy. The nose may also bear the brunt of industrial stress, in those who work in a hot dry atmosphere, or those exposed to acid fumes, or irritating dusts. As the air in our cities is increasingly polluted by exhaust fumes, and industrial irritants, whole urban populations may suffer from chronic nasal and respiratory symptoms.

Of course, nasal reactions are not just infectious, or allergic, or emotional. Particularly in the chronic sufferers, there is an interdependence of all three. Death of a relative, or other psychic shock can pre-

(concluded on following page)

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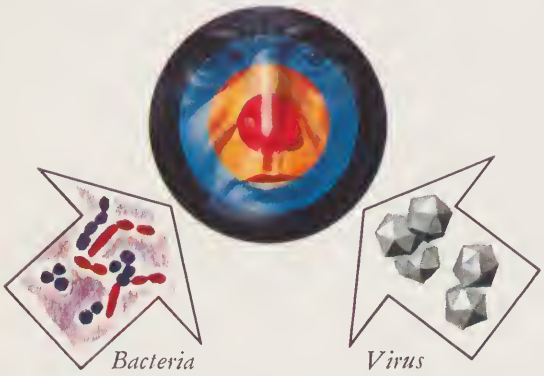
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cipitate an attack of rhinorrhea in hay fever sufferers.[12] Others develop attacks of vasomotor rhinitis following change in temperature, chilling, or exposure to the sun, or simply warm bedclothes.

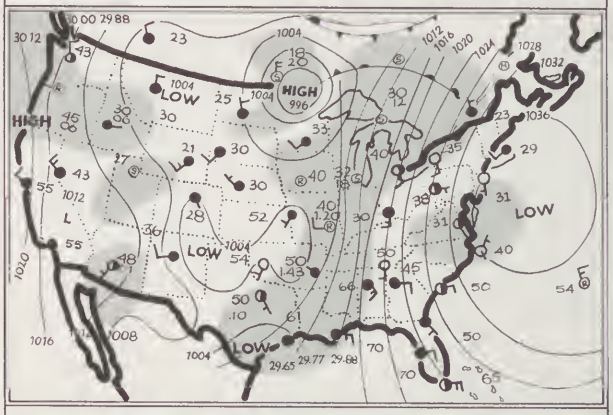


The complex interplay of allergy and infection is largely unclear. Allergy to the viruses and bacteria which cause infection has been postulated, but is difficult to demonstrate. The swollen obstructed allergic nose is more susceptible to infection. At the same time, infection often precedes or precipitates an allergic attack. Exposure of a susceptible patient to an allergen can activate latent virus organisms leading to infection.[13] This "jolt" reaction represents a summation of an allergen and a virus leading to symptoms in the nose as a shock organ, which neither could have produced alone. In childhood, repeated attacks of bronchitis and colds may be inflammatory reactions to an allergen, or precipitated by exposure to an allergen. These children may later develop typical allergic rhinitis. On the other hand, children with typical allergic histories, eczema, asthma, and allergic familial backgrounds, may later develop typical infectious rhinopathies. Skin tests in such patients are usually positive.

Nasal reactions are part of the systemic response of the patient to an unwelcome stimulus. In cases of respiratory infection and exposure to atmospheric irritants, the reactions are useful, and to some extent desirable. They are usually self-limited, disappearing within a few days, or upon removal of the provoking agent. Here the distressing symptoms can be ameliorated with appropriate decongestant agents, or, in the case of severe or complicated respiratory infections, antibiotics may be given, with reasonable confidence of a cure. On the other hand, when nasal reactions are the peculiar response of an individual to an allergen, or to an undesirable situation, they serve no useful purpose. The nose here is a shock organ in a stressful situation, but can furnish no response of value. It merely causes the patient symptoms which add to his problems. In these cases, symptomatic treatment is of great benefit, but often the underlying faulty pattern of response cannot be altered. Such a patient may literally be considered to be paying his way in life "through the nose."

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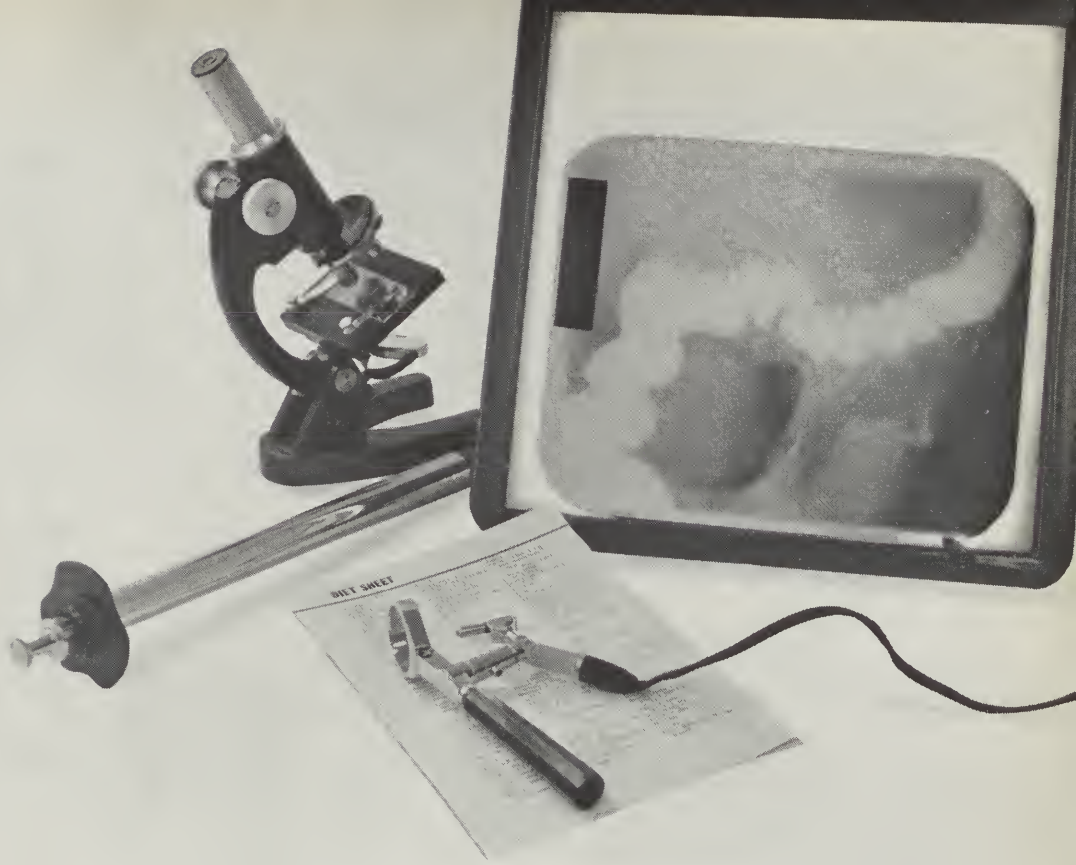
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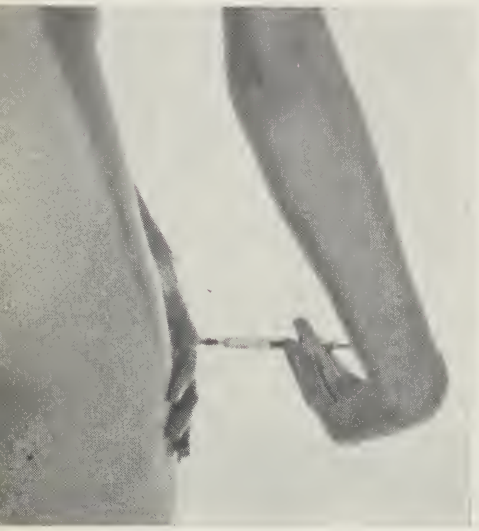
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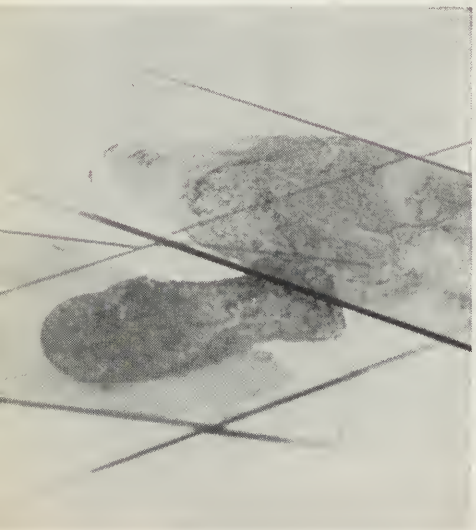
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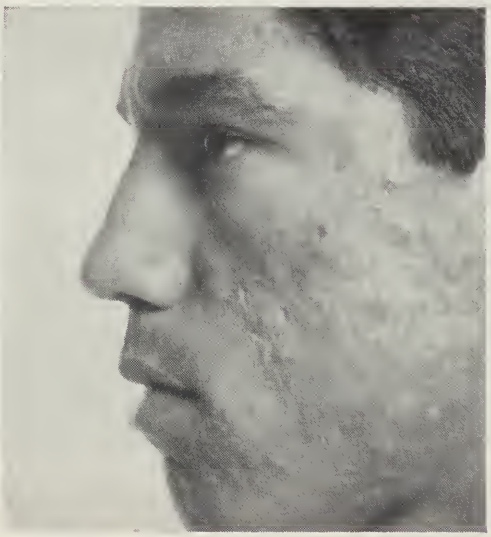
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PROBLEMS OF PRACTICE

W. EDWARD GALLIE, MD

Your kind words of introduction remind me of the feeling I have always had in Baltimore—that, far from being a stranger in a strange land, I am among friends. Not only have I grown up with many of you in our art and science, but I am ever conscious that in many surprising ways your traditions are our traditions. Indeed, except for some considerations of geography and of political institutions, we are one people.

You have probably noticed that in the past few weeks a great and historical political event has occurred in Canada. Newfoundland has at last entered Confederation and has become our tenth province. This must recall to you that the founder of the first settlement on the south-east corner of Newfoundland, the peninsula of Avilon, was the same man who brought the first English settlers to Maryland and gave his name to this city. George Calvert, Lord Baltimore, received charters for both these enterprises from King Charles the First, early in the 17th century, over three hundred years ago.

But of far greater interest to me is the recollection of the contacts I had with some of the men who have made Maryland and American Medicine great. I met Sir William Osler only once, on the occasion when he delivered his famous address to the medical students in Toronto on the "Master Word in Medicine." But my contacts with him go far beyond that, for it happens that I was born in Barrie, Ontario, and received my education in the Barrie Grammar School where Osler had gone to school thirty years before. I actually knew several men who were schoolboys with him at that time and took part in the pranks that have been so well described by Harvey Cushing. The Osler tradition there is very strong.

Sixty years ago to-night Professor Osler was the guest speaker of the Medical and Chirurgical Faculty of Maryland. His subject was "License to Practice." In his address he attacked the existing system of medical education and the absence of safeguards for the protection of the public from quacks, charlatans and shockingly untrained doctors. He asked "Is it to be wondered, considering this shocking laxity, that there is a widespread distrust in the public of professional education?"

Reading this address of sixty years ago has set me thinking of what has happened in medical practice in the intervening years and where we stand to-day in our relationship with the public. At this point one is tempted, particularly in the presence of an audience composed largely of other than the medical profession, to review the glorious record of achievement of the last half century. Even in my own time the forward march of the basic medical sciences and of medicine, surgery, and all the specialties has been almost unbelievable. This era of glorious advancement which has

I. Ridgeway Trimble Lectureship presented at the Sesquicentennial Celebration of the Medical and Chirurgical Faculty, April 25,1949, originally published in the July, 1952, issue of THE JOURNAL, and reprinted here at the suggestion of the son of the doctor in whose memory the lectureship was established, I. Ridgeway Trimble, president of the Johns Hopkins Medical and Surgical Association. The late W. Edward Gallie, MD, was a professor of surgery and dean of the Faculty of Medicine at the University of Toronto.

seen the establishment of our mastery over typhoid fever, diphtheria, pernicious anemia and diabetes, over surgical infections and the hidden diseases of the abdomen, the thorax and the brain, has occurred in the stimulating atmosphere of free enterprise and has been brought about by the unfettered enthusiasm of crowds of young people like Osler and Cushing here and like Banting and Best in my own country.

And as I think of this glorious era I cannot help wondering if it could have happened under state medicine. Would the fires of research have glowed as brilliantly under bureaucrat direction and political control as they have in the immediate past? Could management by the civil service have been as successful in attracting these bright young minds to the study and solution of the problems of health and disease? My experience with politics and the civil service makes me doubt it and makes me think that we should avoid at all cost the introduction of socialistic changes which could so easily kill the goose that laid the golden egg

This craze for socialized medicine is part and parcel of the general demand for social security. It is not a criticism of the quality of the service we are giving, but rather of the cost of it. And when one considers the colossal bills that follow an ordinary illness such as pneumonia or appendicitis, one cannot help sympathizing with the low income citizen when he looks about to see if he cannot get somebody else to pay for it.

The remedy is not too clear at the present time, but in my opinion it should centre on this problem of cost. Some scheme must be discovered which will lessen the load of the ten to twenty dollars a day charge of the hospital and the ten to twenty dollars cost of the nurses.

But in searching for means of reducing the cost of illness, what folly it would be to destroy the good will of the doctors and to make them sorry they had ever come into the profession. The spectacle of what is going on in England and New Zealand, with their schemes of state medicine, is quite enough to drive bright and clever young men into other fields of endeavour. At any rate there will be no sons of doctors entering medical school if state medicine comes. I would venture to predict that with the advent of socialized medicine, as it is advocated by the socialist and communist parties, this golden age of medical discovery will come to a close and we shall enter a period when progress in the study of health and disease will bog down to the speed of the civil service. The idea that medical research can be kept alive by government grants is just silly if it turns out, as I think it will, that the bright boys no longer want to be doctors and will no longer enter the schools.

The appalling cost of illness is largely due to the rise of hospital rates and to the cost of nursing care. Fifty years ago when we took sick we went to bed at home and the doctor came to see us there. To be sent to a hospital seemed like a death sentence. Now, however, largely due to our advocacy of the virtues of hospitals and to the development of the "Blue Cross" and other insurance plans, everybody wants to go to the hospital on the least provocation. The result is an outburst of hospital building at such fabulous prices that the daily rates can do nothing but rise. How we are ever going to get nurses enough to staff these new hospitals is beyond me, for I am convinced that, with the rising demand of industry, of public health, of aeroplanes and of the public schools, for trained nurses, the chances of getting nurses enough to take care of the sick are steadily growing less. Indeed, I feel sure that the day of a plethora of nurses is over and that it is time we were thinking of how we can do without them.

First, let us consider the hospitals. Do we really need the enormous increase of hospital beds that is now being demanded? How many are being occupied by patients who have been sent in for complete laboratory investigation and for observation and who really do not need to sleep in the hospital at all? It seems to me that a great many are in this class. Would it not be preferable, instead of building hospitals, to build clinics where a patient could undergo a complete investigation and then return to his own home? This would speed up the programme, reduce the need for nurses and cut down the expense. It is certainly worth thinking about before calling in the architects.

The problem of the nurses is occupying the attention of hospital administrators and the nursing schools all over the world. The other day I saw a big sign in the Strand in London, England, announcing that the governments of Australia, New Zealand, and South Africa would welcome applications from young British girls to go out to those Dominions at government expense and on

specified salaries to train in hospitals as nurses. The shortage, indeed, is universal.

The reasons given are varied but they all seem to boil down to the fact that to many, nursing the sick has lost its charm. In earlier days a high proportion of the girls entered training schools in the spirit of Saint Anne, gladly devoting their lives to the service of the sick and accepting as their reward the gratitude of their patients and the hope of happiness hereafter. Gradually, however, nursing has changed to a profession, an ill paid one at that, and one that requires high standards of preliminary education and years of special training. In the presence of ever increasing opportunities for young women in business, in pedagogy and in countless other fields, with limited hours of work, week ends off and higher pay, it is no wonder that volunteers are lacking. What the solution is I do not know, but I suspect that it lies along the way of learning to get along with fewer trained nurses, who will occupy the posts of greater responsibility with pay and living conditions such as to attract bright young women, and filling in the vacancies with a lower grade of personnel. However, this is a problem not for the doctors but rather for the hospital administrators and particularly for the nurses themselves. No solution will be satisfactory that does not come from them and carry their staunch support. My only purpose in mentioning it at all is to emphasize what many of us think, that the shortage of nurses is permanent and urgently calls for thought.

Returning to a consideration of the changes in medical education and in practice since Osler delivered this lecture sixty years ago one cannot fail to be impressed with the enormous progress that has been made. What the great physician advocated that night, namely a reformation in clinical teaching and the setting up of high standards for hospitals and medical schools and for licensure to practice, have all been brought about, and, mark you, have been brought about by the doctors themselves. The idea that this kind of reform could have been brought about by any government bureaucracy is the sheerest nonsense.

These sixty years have seen the rise of the internist, the surgeon, and the various kinds of specialists. It is but natural that, with the enormous broadening of the field of medicine, practitioners have been forced to concentrate on narrowing portions of that field in order to maintain a standard of excellence. There are many of us, however, who feel that this swing to specialism has gone far enough and that a little more attention should be paid to the general practitioner. Indeed, for some reason or another, the public seems to have lost a great deal of its former respect for the old style family doctor, and rushes off at once to whatever specialist seems to be most suitable to their particular complaints. It is amazing how often nowadays patients come in who state they have no family doctor and who are quite surprised when I decline to see them except at a doctor's request.

This is most unfortunate for I am convinced it often leads to poorer instead of better service. The ideal family doctor is competent to diagnose all but the most uncommon ailments and he is familiar with the treatment required. If he really is the family doctor he is also a trusted friend who can be depended upon to call the proper consultant if another opinion is needed and to select the most suitable specialist if special treatment is required. Above all, he knows his patients far better than any chance consultant ever can and, being their trusted counsellor and friend, he has their interests close to his heart. When I get sick I want my old family doctor; none of your specialists for me.

But just as Sir William advocated an increase of the medical course from two to four years, with emphasis on basic sciences and clinical study at the bedside so I have to recommend, sixty years later, another extension of the programme of training. It seems to me that with all the advances that have been made in medicine, pediatrics, obstetrics and minor surgery it is impossible for a student, no matter how diligent he may be, to get a practical grip of his subject in four undergraduate years. Almost all this time he has had his nose on the grindstone with lectures, clinics and laboratories and is awake at all hours of the night preparing for examinations. At no time is he given responsibility for sick patients or given the opportunity actually to be the doctor. The result is that while at graduation he has had a better basic and theoretical training than ever given before, yet he has not had sufficient apprenticeship to fit him for actual practice.

To get over this defect in his education he needs a general rotating internship. This, I be-

lieve, should be compulsory and required by the laws of the state or province for licensure. This is actually the law in some places, but it is by no means universal. Some of the leading hospitals associated with medical schools do not have a rotating internship at all. It seems to me that an adequate preparation for general practice requires an internship which includes six months medicine, six months obstetrics and pediatrics and six months minor and emergency surgery, including fractures. If to this were added six months or a year of training with a busy practitioner the course would be complete. Such a plan, of course, would require that hospitals pay the interns a sufficient honorarium to make them independent.

But while making an adequate internship compulsory for licensure would be a great advance, it would fall far short of the ideal unless the medical school takes a much more active interest in the welfare of the intern than it has done in the past. It is notorious that in many hospitals the interns are simply servants who carry out routine work without any pedagogic supervision or spiritual stimulus whatsoever. Everybody must have observed how frequently the lean, alert, anxious medical student degenerates during his first six months as an intern. This comes from the too sudden release of the graduate from the discipline and supervision of school. What is needed is a more gradual transition from the rigours of medical school to the independence of practice. It calls indeed for a continuation of the curriculum of the school into the intern years, with sufficient clinics, discussion classes and practice demonstrations to make sure that the intern is getting the best out of his service. What I am suggesting, indeed, is that we cease to look on interns as servants of the hospital but rather regard them as post-graduate students whose quality as practitioners of medicine will depend largely on our skill as teachers. I am suggesting that we make it impossible for the intern to complete his training without having done, and accepted responsibility for, all the things he must do in practice.

Of the rise of the specialist since sixty years ago, so much has been said that I need only touch on it. Indeed I know very little about it except as it applies to the surgeon. These sixty years, however, have seen an extraordinary change in his education and in his practice. At the beginning he was a general practitioner who had a special interest in operative work and had ultimately become proficient in some of the common procedures. Gradually, however the field became wider including the hitherto unexplored fields of the abdomen, the chest, the nervous system and the bones and joints, so that it became necessary for the budding surgeon to spend years in training before setting up in practice. To protect the public in this period of change, the American College of Surgeons and the American Board of Surgery in the United States, and the Royal College of Physicians and Surgeons in Canada, have been set up to establish the standards of training that are necessary to efficient service. As yet these standards have not been made obligatory, but the time is not far distant when they should be. Just as Osler pointed out the necessity for obligatory standards for the general practice of medicine I now urge that consideration be given to the limitation of major surgical practice to those who have been properly trained for it. The notion that a degree from a medical school and a license to practice granted by a state or provincial board is sufficient qualification for a man to engage in any kind of practice is nonsense and should be corrected as soon as possible. While it is obvious that to bring in restrictive legislation too suddenly would cause hardship and arouse so much resentment and resistance that the needed reform would be retarded, I feel sure that if the problem is handled wisely both the public and the profession will agree to proposals that guarantee that the practitioners to whom are entrusted the lives and limbs of our patients have been adequately trained. Just as there are now minimum standards set for licensure for general practice so there should be minimum standards, such as those required by the Boards, for license to practice a specialty.

In these times when various forms of socialism are sweeping over the world it is particularly important that we should retain the confidence of the people. We have been and still are looked upon as an honourable profession, doing our daily work because we like to do it and concerned more with the service we give and the satisfaction we get out of it than with its pecuniary rewards. It is very essential, just now, however, when people are resenting the rising cost of medical care that we do not occupy a prominent place in the general clamor for higher pay. I really believe that the

most useful service we could give to the public as well as ourselves would be to do everything possible to reduce those rising costs. The lavish use of expensive drugs, the multiplications of x-rays and the free use of physiotherapy make the bill that the patient must pay on leaving the hospital truly astronomical. Over and over again I have heard of low income people such as university professors who literally had to mortgage the house to pay for an illness. Now while the doctor's bill is a mere fraction of this cost, yet the patient is inclined to blame the doctor for it and to a certain extent he is right.

The other day a friend of mine, a professor of mineralogy, consulted his physician about some discomfort in the upper part of his abdomen. After taking the history the doctor decided that hopitalization was necessary in order that a complete investigation could be carried out. The patient entered a hospital on a Friday night, but by that time the physician had gone out of town for the week end and he did not get back till Monday afternoon. He then ordered a gastrointestinal series, a gall-bladder series, chest and spinal x-rays, an electrocardiogram and the whole list of blood and urine analyses, with particular emphasis on liver function tests. He wanted to make sure that nothing was overlooked. So all his investigation was completed and one by one the tests were reported negative. In the meantime the patient had completely recovered from his indigestion. He left his ward with a spring in his step and the light hearted feeling of one who has had a narrow escape from catastrophe. This lasted till he reached the wicket where he received his hospital bill. Then all the symptoms returned with threefold intensity. The fact that the doctor, being a fellow member of the faculty and a personal friend, didn't send him a bill, didn't seem to help.

I suggest, therefore, that we do not send anyone into a hospital not urgently needing to go, that we pause a moment before ordering a list of expensive clinical investigations that have no direct bearing on the case, and that we reserve the use of antibiotics and whole blood for patients who really need them.

It is particularly important in these changing political times that we do not leave ourselves open to the charge of commercialism. Of course we want to make a decent living and to have incomes that will enable us to live in social equality with those of a similar cultural status to our own. But we should also have the credit for the perfectly enormous amount of service that we render without any charge whatever and without a hope of financial reward. The public can hardly be made to believe that the staff appointments to our inpatient and outpatient services carry no salaries or honoraria. But much more spectacular than the day by day free contribution of the doctor to the general public welfare are the wonderful gifts to humanity that have been made by medical research.

The one that I know best is that in relation to diabetes, for once upon a time Sir Frederick Banting was my house surgeon and Charles Best was my student. When one realizes that there are nearly a million diabetics in the United States and Canada who are being kept alive and in good health by insulin, what a killing those two boys could have made if they had capitalized on their discovery. If for instance they had sold their process to the manufacturers with a royalty of one cent a day from each patient, that would have amounted to $3 million a year. And that they did not do this was no mischance for I can assure you that I listened one night twenty-five years ago to a full discussion of the subject by the insulin committee of the University of Toronto, where with a complete realization that the discovery was a success and that the income that could be derived from it would be enormous, the discoverers in cold blood decided to live up to the traditions of our profession and to hand over their discovery to the world. This is something that is understood neither by capitalists nor communists, but it is one of the glories of our profession that make us resent the suggestion that in the future we are to be pushed around by bureaucrats and civil servants. It is my firm conviction that if thirty years ago medicine had been socialized on one of the plans now being threatened, Frederick Banting and Charles Best would never have registered in a medical school and the diabetics would have been dying of coma as usual.

It is my pleasant duty to bring to you the greetings of the Canadian and Ontario Medical Associations. Just as you represent the doctors of Maryland and of the other United States, so our Canadian Associations speak with authority for the medical profession in Canada. Our association with you in times of peace, over the last hundred

and twenty years, and in times of war, in the last thirty years, has done nothing but raise our admiration for you. The kindly way in which the Canadian doctor is received in the United States never fails to astonish us and to arouse our deep appreciation.

In these anxious times when there hangs over us the threat of atomic war and we figuratively scan the northern skies in search of enemy aircraft it may be comforting to you to know that here and there along the shores of the Arctic Ocean and of Hudson's Bay are increasing groups of Canadian airmen and radar experts. This was brought home to me most forcibly when a well-known surgical colleague, one of the senior medical officers of the Royal Canadian Air Force, flew to Baffin Land to inspect the medical arrangements in that far Arctic post. It is just unbelievable.

One thing we Canadians are terribly keen about is that the proposed St. Lawrence waterways scheme may be proceeded with soon. By building canals to bypass the 75 miles of rapids in that great river we can open it to ocean navigation for an increased thousand miles and convert the ports of Cleveland, Toronto, Detroit, Chicago, Fort William and Duluth into ocean ports. Just as the completion of the Panama Canal made commerce originating in one ocean available to the other, so the St. Lawrence waterways will extend that commerce from the outside rim to the very centre. Strategically, too, its importance is enormous. While I know that New York, Boston, Philadelphia and perhaps Baltimore are not very keen about seeing some of their shipping proceeding up the St. Lawrence, yet in time of serious war, the more we are spread out and the less vulnerable we are to atomic bombs the better.

Just to guard against a possible feeling of disappointment among the more scientifically minded of my audience that I have said very little about practical surgery, I shall dwell lightly on a curious cult that has developed recently among the surgeons. From time to time I have held forth against the indiscriminate introduction of foreign bodies into the delicate human organism and have pointed out the evils that may result from this unscientific practice. Now, however, I would draw attention to a growing habit of dealing with certain injuries and diseases by cutting off the offending part and throwing it away. It would suggest that our faith in a Divine Providence has become so undermined that we have begun to look critically on what we have always been taught is the noblest work of God. The suggestion is that perhaps, after all, the hand of the potter does shake. The other day there came under my care a great professional hockey player who had fractured his patella. All my young colleagues told me that the newest and best treatment would be to remove the patella; simple, free from danger and effective. Now, of course, I knew all this and have seen results that would be quite good enough for the knees of those young doctors, but I had to remember that my patient was a great centre player and that one reason he was sent to me was that I also had been a hockey player and knew something about the kind of knees that centre players must have if they are to continue to play that great game. So I stuck to the old accepted plan of trying to restore the poor boy to the mould in which God made him.

The speed with which the "cut off and throw away" cult has developed is amazing. It used to be limited to feet and fingers and hands but now it includes patellas, olecranons, clavicles, gall bladders, cecums, colons, stomachs and lungs, and when the technique for each of these has been perfected we are calmly told that no ill effect from the loss of the part can be detected. The climax, as far as I am concerned, came not long ago when the neurosurgeon brought in a patient from whom he said he had removed one cerebral hemisphere And sure enough, there was the hemisphere in a bottle. I asked the man how he felt about it and the mumbled reply did not impress me. The surgeon assured me, however, that the patient had always talked like that and that the loss of half his brain had seemed to have no ill effect whatever.

Well, I must not go too far in this discussion for fear I leave a wrong impression. I think it is well worth while, however, for the surgeon to pause when he feels the urge to cut off something coming over him, and consider that, while it is interesting and often very important to know that man can get along without some of his parts, in the millions of years in which the process of evolution has been going on the chances are these parts have gotten used to one another and might not play the game quite so well if some of them were missing. It might be well if these enthusiastic surgeons, before trying out these

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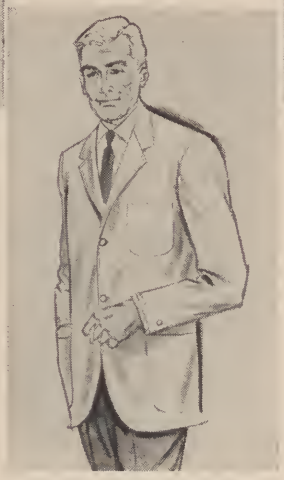
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newfangled stunts on their patients, did as Banting and Best did when, before giving the new drug "insulin" to their patients, they tried it out on themselves.

The association of our tenth province, Newfoundland, with Maryland reminds me that the other day in London certain sentimental people gathered about the great equestrian statue in Whitehall to mourn the passing of the king who sent Lord Baltimore to America. It is a bright commentary on the character of the English people that there are some who every year, on January 30th, stand about this statue and drink a toast to the rightful king (over the water). The Lord only knows who the descendant of the Stuarts really is. Certainly the Jacobites do not. And while the toast is being drunk another crowd looks on with an amused yet sympathetic smile and then all move off together as loyal subjects of King George the Sixth. A great and interesting people, but to us on this side of the Atlantic, sometimes hard to understand. King Charles the First was not a wise king, and he certainly was a most unlucky one, but in his magnificent exhibition on the scaffold of Whitehall he made a glorious atonement. So when January 30th comes around, you in Maryland, so named in honour of his queen, who could not possibly drink to a king named George, may raise a glass with me, a descendant of Scottish Jacobites, to Charles Stuart, the founder of your country and to Mary his queen.

THE FINANCING OF A MEDICAL EDUCATION: WILL THE HOUSE OFFICER BECOME THE FORGOTTEN MAN?

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The costs to an individual of funding his medical education from the first year of college to the last year of residency are extraordinarily high. A detailed study of medical students during the 1963-1964 academic year shows, for example, that the average unmarried student spent $2,713 for all costs, including taxes, while the married student without children spent $4,797.[1, 2] Subsequent increases in school and living costs would make those figures higher at the present time.

No comprehensive study of the costs of house staff training is yet available. However, in 1965-1966, the average intern salary, exclusive of fringe benefits such as food and housing, was $3,578 for physicians in hospitals affiliated with medical schools and $4,071 for those in non-affiliated hospitals.[3] First-year-resident salaries, similarly computed, were $3,818 and $4,059, respectively.[3] These facts, superimposed on the observations that about 60% of senior medical student are married,[1] and that perhaps one-fourth or more have significant non-family debts at the time of graduation,[3] point to important financial problems for house officers. Much concern has been expressed about the relatively high family-income groups from which many medical students come.[1] One might seriously ask how much self-selection occurs among potential pre-medical students of relatively low income as a result of the long-term funding problems hinted at above.

The opinions of the author are not necessarily those of the University of Maryland School of Medicine.

For background information, non-family sources of financial aid to medical students in 1965-1966 are summarized in the Table.[3]

Source	*No. of Awards*	*Average Award*	*Funds Expended (million)*
School loans	3,372	$483	$1.63
AMA-ERF loans	3,928	$1,089	$4.28
Federal loan programs	11,488	$865	$9.88
Other loans	2,164	$802	$1.74
Total loans	20,952	$837	$17.53
School Scholarships	6,367	$709	$4.51

Clear-cut changes are occurring at the present time, however, in the pattern of medical students' funding of their education almost entirely as a result of two important Federal programs. The early growth of the first, the Federal Health Professions Loan Program of 1963, is apparent in the Table. Loans from this source are interest-free until repayment begins three to five years out of medical school. At that time, simple interest at the going federal rate, presently 4.62%, on the unpaid balance begins to accrue. The repayment period is ten years.

The second federal program for medical stu-

dents, the Federal Health Professions Scholarship Program of 1965, is quantitatively much smaller but far more select: scholarships may be offered to students of "low income families who could not otherwise continue their studies." Such grants first became available during the present academic year. At the University of Maryland School of Medicine, for example, 13% of the Class of 1970, the only class presently eligible, are receiving such support, with average stipends of about $1,100. The regulations allow the Faculty to establish a "reasonable" total educational debt limit for such students; at Maryland it will be $5,000.

The expected further growth of these two critical federal programs should at least move medical student funding of education in the direction of the goal described by a large number of students in 1960—one-third from each of the following: (1) the student, his family, and/or spouse; in the form of current income or savings; (2) society, in the form of scholarships; and (3) the student, in the form of future indebtedness.[4]

Particular note should be made of the American Medical Association's loan program. In each of the three academic years, 1963-1964, 1964-1965, and 1965-1966, this fund has been the source of a little over $4 million loan money for medical students.[3] In contrast, federal loan programs grew in those academic years from $2.9 million to 6.2 million to 9.9 million, respectively.[3] American Medical Association loans, basically bank loans guaranteed by the AMA-ERF Fund, are significantly different from those provided through the federal programs in that they may be given both to students *and* to house officers. Originally, an AMA-ERF loan was limited to $1,500 per year; 5.5% interest began to accrue at once, but no repayment was necessary until the physician had finished his house staff training. He then had 10 years for repayment on a new note bearing 6.5% interest. Because of the high cost of money at present, maximum loans have, unfortunately, been reduced to $750. Furthermore, not only have the interest rates recently risen from 5.5% and 6.5% to 6% and 7%, respectively, but the 6% interest due for the education and training periods must now be paid as it accrues.

What are some of the implications of financial aid and obligation as they pertain to the house officer? In unpublished work we have undertaken at the University of Maryland School of Medicine, there is the preliminary suggestion that students with large debts or with children tend to seek out internships paying relatively high salaries. In some instances, such house staff experiences have appeared to substitute financial reward for quality of training. At the opposite end of the spectrum, many teaching hospitals have paid small salaries and then reacted strongly against their house staff for "moonlighting" activities. In contrast, with the growth of the federal loan program, medical schools, including Maryland, feel far more secure now about strongly discouraging weak students from outside employment during the academic year.

From the long range viewpoint, the possible impact on the young practitioner of his high debts and previously austere living standard, on the one hand, and of his sudden access to the patient's money, on the other, seems alarming. Other long-term problems worthy of careful scrutiny almost certainly have arisen for the medical student and house officer as a function of his prolonged dependency on his family for financial aid and his and his spouse's ambivalence about when to start a family. Certainly, the family and financial pressures on the young physician in training are much greater, age for age, then those on other bright, productive, and highly educated members of society.

What hope is there that some of the potential and real financial problems of the house staff period will at least decrease in intensity? As noted, the house staff member's key source of financial aid other than moonlighting, ie, the AMA-ERF loan, has recently been cut to only $750 per year. Furthermore, a bank loan without the backing of the AMA-ERF is often quite difficult for house officers, a peripatetic group, to obtain.

Should and will government intervene in some fashion to rescue the house officer from his financial plight? The favorable impact of federal policy, for example, on the financial problems of the *medical student,* in striking contrast to the continued predicament of the *house officer* in the absence, to date, of any such policy suggests that it should; the concerns of three federal programs suggest that it will: Both (1) the Medicare-Medicaid program, under Public Law 89-97, and

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(2) the Regional Medical Programs for Heart Disease, Cancer and Stroke, under Public Law 89-239, can be expected to become increasingly involved with services to patients and thus with the house officers who supervise or provide them; and, although research grants will of course continue to comprise the larger portion of (3) the Public Health Service Research and Training Grants, the PHS appears to be showing an increased interest in training grants.

In summary, the financial problems of the medical student are seen as serious, but easing, and those of the house officer as severe and likely to be more so. It is to be hoped that the next few years will see real advances in this key area.

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PROGRESS AND STAGNATION IN PSYCHIATRY DURING THE PAST FIFTY YEARS

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The merits of our mental institutions can now be evaluated on the basis of a century of experience. Although there is still widespread disagreement on theories of psychiatry, substantial advances have been made in general endorsement of the practices of psychiatry insofar as patient management is concerned. Some of these areas of agreement involve concepts first promulgated from 50 to 100 years ago. A brief history of theories and practices is presented, today's mental hospitals are assessed and steps necessary for their continued improvement are recommended.

It seems fitting and appropriate, on the occasion of any anniversary celebration, that we pause and reflect on the lessons which history has to teach us. As others have pointed out before, we have only two choices with respect to history: either we study it or we repeat it. In other words, we either learn from the past or repeat the mistakes of the past. The half-century which has passed since the founding of this hospital has represented the most dramatic phase of all civilization. Probably more changes have taken place during this period than in the thousands of years before. A question which must nag us relentlessly asks if the progress which civilization has made during this half-century has been paralleled with a corresponding degree of progress in our own field of psychiatry, and, in particular, a corresponding degree of progress in our public psychiatric hospitals. In the search for an answer to this question, let us, for a moment, imagine ourselves living in the year 1915 and take a look at what was going on then in the field of our interest.

One of the events that took place in that year was recorded in an issue of the journal *Modern Hospitals*. The notice was entitled "Maryland opens a new hospital for the insane at Cambridge" and went on to say: "The group (of buildings) consists of a main hall, laundry and power house. The main hall is 300 feet long and 165 feet wide. It is two stories high, has a cellar under the whole building, and two dormitory wings for male and female patients. All buildings are constructed of rough brick. The second story of the main building is finished in rough cast mortar. All floor construction is of reinforced concrete and the finished floors on the first story are tiled. The new hospital in its present state represents an expenditure of $300,000. As the need increases and more money becomes available, six additional dormitories and an administration building will be erected."

The account is remarkable for its attention to the details of the brick and mortar aspects of hospital construction, and its lack of concern for the purpose for which the hospital was built or might be used—this being presumably implicit in

From an address made on the occasion of the 50th Anniversary of Eastern Shore State Hospital, May 1965

the specification that it was a "hospital for the insane." Such a point of view was representative of the prevailing concepts then, namely that the mere building of institutions to house this class of patients somehow, magically, solved whatever problems these patients presented to themselves and to society.

The most important event taking place in 1915 was World War I. Even though the war was then only one year old, and the U.S. had not yet become involved, psychiatrists were already taking a lively interest in it. The psychiatric condition then called "shell shock" had already been identified, written about and widely discussed. By 1917 at least two complete books had been published on the subject. One in particular propounded a theory which proved very unpopular with psychiatrists, namely that the condition of soldiers called shell shock had something to do with the problems a human being faced in coping with the terrifying prospect of being killed. Much more popular theories suggested that it might be the loud noises of the battle field which brought about these emotional states, the noises having a harmful effect on brain tissue in some unspecified manner. This attitude was derived from prevailing concepts which sought mechanistic explanations for human behavior and resisted the obvious conclusion that the state of fear so often seen in psychiatric patients might be related to the patient's exposure to danger. The mechanistic view was expressed in an article of the *Journal of the American Medical Association* in 1915 by a British psychiatrist who stated "The present campaign in Flanders has made such unexampled demands on the nervous system of the soldier that we are not surprised to meet with many cases of brain damage, manifested as neurasthenia, hysteria, and various disturbances of the special senses."

A president of the American Psychiatric Association during this period offered an interesting observation: He noted that both French and German psychiatrists had reported that there seemed to be no increase in the incidence of psychosis in the civilian population in the war zones, but he asked the cogent question that maybe it would be more appropriate to ask whether or not psychotic people caused the war rather than asking whether or not the war caused people to be psychotic. This objective view of the war was in sharp contrast to a more partisan one expressed by a speaker at an annual meeting of the APA: "When that unspeakable brute, the Prussian Kaiser, that sanctimonious crocodile, drew his hideous and slimy length over Belgium, a good many people sat up, rubbed their eyes and began to take notice." His anticlimactic statement did not go on to say what these presumably observant people noticed, however.

World War I had an important impact on American thinking in many pervasive ways. In a sense, the United States grew up then, became an adult nation and a co-leader of world affairs. This maturation required a breaking away from mother Europe, and the War had a lot to do with the process. As in the case of many other adolescents, it was accomplished by means of a hostile rebellion against the parent in which our own country's "image" was built up by the tearing down of Europe's image. Germany, previously the fountainhead of medical science, became the target of rebellion. In psychiatric circles, this nation-wide move was expressed in a speech given at a meeting of the APA in which an officer of the association stated: "The German scientists excell in their genius for advertising themselves. On a slender basis of achievement they have contrived to impress themselves as the most scientific nation. Never has there been a greater imposture! They display the same cleverness in foisting on a gullible world their scientific achievements as their shoddy commercial wares."

Carrying the same theme to the specific field of psychiatry, he went on to say: "Psychiatrists have been infatuated with German pseudo-discoveries. Novelty of terminology has been mistaken for originality of thought, and their works on insanity have been accorded undue authority." He was alluding then to Freudian psychoanalysis, a doctrine which was then regarded by many as akin to the fear, expressed years later, of creeping communism.

Retreating from the global problems presented by World War I to more local issues, it is interesting to note a prophecy made by a prominent physician of the time. He reported that the British had taken under serious consideration a plan to provide free medical care for the poor, and predicted: "On the American continent little attention has been given to measures of this kind, but it seems probable that, whether medical men like it or not, a similar one will become law on this side

of the Atlantic." It was some time before the issue he referred to became known as "socialized medicine," the war cry of the American Medical Association today.

Another national issue was highlighted in an article in one of the journals and another prophecy made, when the author wrote: "The vendor of quack medicines is busier today than ever. He is a specialist in distortion who probes into the ordinary sensations of healthy people and perverts them into symptoms. Every billboard, newspaper, fence rail and barn thrusts out a suggestion of sickness as never before. The only vulnerable point at which to attack the vicious traffic is the advertising. If the government (passes laws) to forbid this (kind of advertising), the next generation will be healthier and richer." The same author also observed that national prohibition was certain to become law, and prophesied that, once this happened, the evils of alcoholism would finally disappear.

Frequent articles in the literature of 50 years ago came forth with pleas for improving the caliber of personnel working in mental hospitals. Few then were trained people. One article reported a survey of midwestern institutions and found that the average salary of state hospital attendants was $30/month plus maintenance, as compared with double that amount for similar positions in general hospitals. It noted that the turnover before the war had been 75%/year, and urgently recommended substantial salary increases in order to attract and hold better personnel. The article also made a special plea for hiring social workers in mental hospitals, noting that 200 general hospitals had already done this, but no mental hospitals had.

The New York Hospital Development Commission issued a report in 1915 of a survey it had made of the mental hospitals of New York. The report observed that many deficiencies existed in these hospitals and offered the following explanation: "The defects in our hospital system and in the individual institutions are not due either to our very efficient Hospital Commission, or to the management of the separate institutions. Rather, they are due to an unawakened public conscience, a lack of knowledge in the medical profession and the reluctance of the State Legislature to appropriate enough money." It was more common, then, to attribute observed defects to the administration of the individual hospital rather than to the public or the legislature or, least of all, the medical profession.

The literature concerning mental hospitals in that era was largely preoccupied with housekeeping, records and economy. Very little attention was directed toward rehabilitation of the patient. For example, a controversy raged over the relative merits of large, centralized dining facilities for patients. One enthusiastic report from New York State, richly illustrated with photographs, described a major administrative triumph in developing a system for feeding as many as 1,500 patients at one time in a huge dining hall. The report gave explicit details on how this was accomplished. It even suggested that a small orchestra be provided to supply music during the meals, and gave a sample program of musical selections. It recommended that "lively marches" be played as patients entered the dining hall, then "quiet waltzes or lullabies" during the meal, going on to a "rising tempo" of "stirring selections" to induce patients to finish their meals and leave.

On the other hand much attention was paid to cost-cutting procedures, a reflection of institutions' subservience to the penny-pinching attitudes of state legislators. It was during this period that a tradition arose for measuring costs of patient care on a per diem basis (with the greatest status accruing to hospitals which had the lowest per diem rate) rather than on the more meaningful total cost-per-admission basis. Although it was never pointed out then, the hospitals with the lowest per diem costs had the longest average periods of hospitalization, and therefore the largest costs per admission.

Outside of the mental hospital literature, other journals, such as the *Johns Hopkins Bulletin*, published reports and recommendations that were more closely related to the question of restoring the patient to useful citizenship. A number of psychiatrists began to observe that the specialized mental hospitals had become too remote and isolated from the mainstream of community life, and urged the inclusion of psychiatric services in general hospitals in order to make psychiatric care more immediately accessible and acceptable to patients in the earlier phases of their psychiatric difficulties. The Phipps Clinic at Johns Hopkins was a leader in this movement, and it was able to report a much more rapid turnover of patients

than could the State hospitals. Only a half dozen or so general hospitals in the country then had psychiatric services.

Adolf Meyer, at Johns Hopkins, came out with an impassioned plea for the inclusion of psychiatric training in medical school in order to give all physicians a background of skill in handling psychiatric problems in general practice. He stated: "From time immemorial, the physician has been urged to treat not only the diseased organs but also the patient. Of late years we have learned to realize that indeed some disorders can be explained and treated as abnormal ways of living rather than as abnormal functions of an organ. We have also come to learn that the total unified adjustment of the person can be reduced to intelligible processes; to defects of development, intellectual, affective or conative; and to improper use of assets. We teach students chemistry, physics and biology, but not the elements of behavior and mentation. If we do not supply this deficiency in training, the student might be guided into obscure mystical cults and become involved in fads and fashions, and empty squabbling before a justly distrustful public. A new and unnecessary profession of 'clinical psychology' will grow up and fill this gap unless we show the sense and capacity to furnish medical students with the needed training in psychobiology." Meyer's searching analysis and predictions for the future found practically no supporters outside his own domain.

The Massachusetts Board of Insanity issued a report which was echoed by similar observations from a few other sources. The report noted that there were no extensive follow-up services for discharged mental hospital patients, in the absence of which discharge was often delayed and readmissions were encouraged. It made a strong plea for the development of outpatient facilities for following up patients, and suggested that social workers might find a unique and valuable place in these services. The National Committee for Mental Hygiene reported that it had already opened an outpatient mental hygiene clinic in Baltimore which, primarily, handled juvenile problems brought to the attention of the courts, and urged the adoption of this kind of service elsewhere, in the interest of preventing institutionalization.

In the field of psychiatric theorizing, lively debates were going on in 1915, as they had been for a long time. The target of most of the controversy then was Freud, and the principal, but not sole, opponents to the doctrine of psychoanalysis were those who were trying to prove an organic etiology for psychiatric disturbances. By 1915, Freud was well-known in the United States, and his supporters here included A. A. Brill, Smith Ely Jelliffe, and William Alanson White. A psychoanalytic society had been organized in New York City, and a journal of psychoanalysis was in its second year of publication. Already, the field of psychoanalysis had become splintered with its own internal dissension. Jung and Adler had, by then, broken off from Freud to develop what was then referred to as the Swiss School. The argumentation which took place frightened off most of the psychiatric departments in American medical schools, and they tended to rally around Adolf Meyer to oppose Freud.

The organicists were continuing to issue reports which attempted to prove that psychiatric problems were caused by a disease of the brain. One even sought to attribute psychosis to chronic constipation. A prominent psychiatrist of the time, Dr. Southard, a former president of the APA, came out with a thorough-going castigation of psychological theories and submitted autopsy material which "proved" that 90% of psychotic patients had specific brain lesions at the time of death, the site of which determined whether the patient had been suffering from delusions, hallucinations or other psychopathology. Adolf Meyer brought out a rebuttal to these claims with the obvious observation that the autopsy material revealed only the results, not the causes of a lifetime of vicissitude.

The case for the organicists was strongly strengthened, however, by an important discovery of this period. Moore, at Central Islip State Hospital in New York, and Noguchi, at the Rockefeller Institute, established convincing proof that the condition we now know as "neurosyphilis," then known as "general paralysis," was caused by an infection in the brain by spirochetes. Only a few years later, von Jauregg in Vienna discovered the malarial method of treating neurosyphilis. This determined the principal preoccupation of therapists in mental hospitals for the next twenty years, largely to the exclusion of patients there who did not have neurosyphilis.

Medical reports from mental hospitals at the time were replete with articles on the incidence of conditions such as tuberculosis and vitamin defi-

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SOURCE: DUNCAN, G.G.: SCIENCE NEWS LETTER, 83:403 (JUNE 29) 1963.

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SOURCE: JAMA 186:65 (OCT. 5) 1963.





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*SOURCE: ARCHIVES OF GENERAL PSYCHIATRY 8:26 (JUNE 1963).

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ciencies among patients, but it was then rare for anyone to consider the possibility that these conditions might be a result of the unsanitary and un-nutritious state of affairs in many of the institutions. This situation was reminiscent of one which prevailed during the 19th century, when many clinical reports discussed the high incidence of a condition among psychiatric patients known as "hematoma of the ear." It was assumed that a condition so close, anatomically, to the patient's brain must be correlated with the brain disease which was initially assumed to be the cause of the mental disturbance. It was many years before it was discovered that these hematomas were the result of physical violence to the patient on the part of attendants. These examples reveal the reluctance of the institutional physicians of the time to conclude that institutionalization itself could have anything but a beneficial effect on their patients.

These little vignettes of 1915 provide interesting glimpses of that period and, though not comprehensive, are representative of the state of affairs at the time. Before comparing this picture with the one which exists today, some remarks are in order concerning the total history of our psychiatric institutions.

It was during the latter half of the last century that the models for the various kinds of institutions we have today were developed. Then, perhaps for the first time in history, the realization spread throughout Europe and the United States that the lot of each man had some bearing on the lot of other men. The rich and the privileged could no longer be complacent in their concept of a comfortable world for themselves without regard to the masses of underprivileged people surrounding them. A major factor undermining this complacency was derived from the medical advances made in the latter part of the 19th century. It was discovered then that the great epidemic diseases, such as typhoid, cholera, dysentery and tuberculosis, were spread by man-made activities. There was good reason to suppose that a permanent reservoir of these killers resided in the poverty-stricken slums of the cities and that common problems of food and water supply and of sewerage disposal were instrumental in spreading contagion. The privileged leaders of society came to realize that they were not immune to these plagues and that, as long as they prevailed among the poor, those who were better off socially and economically could be damaged by them. This awareness started a middle class revolution to clean up the cities in order to reduce these dangers, and these efforts took the form of cleaning up the poor. Again, with good reason, the middle class leaders assumed that their own standards of cleanliness, sanitation, nutrition, etc., were superior to those of the poor and if the former could be instilled in the latter then all would be protected from the contagion which was rampant.

The adoption of middle class standards was a slow and difficult process, however, partly because they entailed large public expenditures, and partly because the level of sophistication of the mass of the people was not high enough to excite ready cooperation. One of the possible solutions to this problem was to create artificial environments in which the less fortunate would be placed, and where control of sanitation, nutrition, etc, fell under the care of the more sophisticated elements of society. This was the philosophy which provided the justification for the institutions which developed in the last century—prisons, orphan asylums, schools for the retarded, general hospitals, homes for the aged, and, of course, mental hospitals.

It became further apparent that the people who were placed in these institutions were, thereby subjected not only to middle class standards of living, but also to middle class standards of morality. This realization further justified the concept that those who operated these institutions knew better than did the inmates what was good for the latter. Such a philosophy did not need open expression to be promoted, but became a tacit assumption in the development of our system of institutions. It must be said, however, that there was then some validity to it, for no matter how badly these institutions were run, they often provided a substantial improvement over the environment from which the inmates came. It can now be stated affirmatively, that whatever good was accomplished by institutional care during that period was determined by the degree of improvement in the life and environment otherwise available to the people served. The same can be said today, although conditions have changed greatly during the last century. There is much more doubt now than there was then, however, that the institutional environment is a better alternative than what is available outside.

The great institutional experiments of the past

century are examples of what we call today "social engineering" in that they represented attempts to create controlled environments not subject to the laissez faire processes in the evolution of our urban and rural communities. The hundred years of experience now at hand should enable us to judge whether these institutions have, in fact, lived up to their promises, and if there is still a place for them in modern society.

Hardly anyone today believes that our **penal institutions** have had a beneficial effect in deterring crime or in rehabilitating the offender. A number of dramatic reports have come out in the past 25 years to show that **orphanages** create more problems than they solve, and the findings have resulted in the closing of most of these institutions. Fortunately foster care and adoptive homes have been available as alternatives to the orphanages, but no alternatives to prisons have yet been created in our country. Institutions for **the aged** are generally regarded as falling far short of the kind of decent and humane care we would want for our own aged relatives, but better alternatives are only slowly evolving and are far from commensurable with the rapid increase in our aged population. Some European countries have done much more than we have in creating decent, livable communities for their older citizens. **General hospitals** are beginning to be looked upon not as places to house people during illnesses, but as places where it is convenient for physicians to administer very specialized treatment and diagnostic measures for only very brief periods during the course of illnesses.

Turning our attention back, now, to the problem of our **mental hospitals,** let us ask ourselves if the things we have learned in the past fifty years about the treatment of psychiatric problems are adequately expressed in corresponding advances in the building and management of these hospitals. Those of us who are intimately involved in the inner circles of psychiatry are both more impressed and more dismayed than those outside by the persistent turmoil of controversy which still prevails among us: we cannot say (and we should be ashamed to admit this) that we are any farther ahead now than we were in 1915 in arriving at a consensus in the matter of *theory*. For example, there is probably no one single theoretical point of view subscribed to by more than 20% of today's psychiatrists, and the most popular theories are probably the most incorrect ones.

We have, however, come closer together in the *practice* of psychiatry. A substantial number of solid advances in patient management are now widely endorsed in principle. Invariably these areas of agreement involve rather obvious, commonsense concepts from which physicians have frequently strayed far afield in the past. For example, in the 1850's, over 100 years ago, Thomas Kirkbride (then superintendent of the Pennsylvania Hospital in Philadelphia) led the way toward getting the American Psychiatric Association to adopt "26 Resolutions" declaring its consensus on the matter of certain basic guidelines in the management of mental hospitals. One of these resolutions was the firm assertion that no hospital should have more than 250 beds, that number being the largest number of patients which it was thought the medical director could get to know personally. Within ten years of the passing of this resolution, however, public mental hospitals had grown to more than double that size. Since then, the 300 public mental hospitals have grown to an average size of 1500 beds, while the largest one, in New York State, has 16,000 beds! The final report of the Joint Commission on Mental Health and Illness, "Action for Mental Health," which is currently serving as the "bible" for mental health planning, recommends that these hospitals be reduced to less than 1,000 beds in order to be manageable. This idea is now widely accepted, and some states are taking pride not in how big their hospitals are, or in how much they are growing, but in the degree to which they are succeeding in reducing the number of beds. As a result of this reversal to Kirkbride's original policy, there has been a small, but constant decline in the total patient population since 1955. One hospital in Iowa has achieved a remarkable reduction in beds from 3,200 a few years ago to 800 this year. The state of Massachusetts now has a policy of "bed liquidation," whereby substandard buildings are steadily eliminated and are not replaced by new ones.

Another area of common agreement encompasses the realization that institutionalization, itself, creates problems. It is recognized now that the longer a patient stays in a hospital the more difficult it becomes to get him out. This happens as a result of several factors. In the first place, the passage of time in the hospital is often accompanied by a progressive abandonment of the patient

by his relatives, his friends and the community—leaving nothing on the outside to which the patient can return. Secondly, since institutional life removes personal responsibility from the patient, he is likely to become increasingly dependent upon the institution, and his independent existence outside is thus jeopardized. The danger of prolonged hospitalization becoming permanent is so great that it pays to take long chances, if necessary, to get the patient out as soon as possible. The risks the hospital and the patient take have to be shared with the family and the community, and the reluctance of the latter to take such a risk is one of our greatest obstacles today in rehabilitating the patient.

Another rather obvious concept which hospitals generally accept today, but had largely forgotten during previous generations, is the one that advocates the involvement of patients in useful employment during hospitalization. Failure to do so is a prime factor in making patients dependent upon the institution.

The mass herding of patients in hospitals, practiced in the past for purposes of economy, is widely recognized as another factor which robs patients of individuality and initiative. More thought is now being given, therefore, to the management of patients on an individualized basis. Little things which help bring this about include replacement of uniform dress with individual variations, facilities in which patients can keep and care for personal possessions, smaller wards and smaller dining areas.

The proposals cited above from the 1915 era for outpatient follow-up services were extremely timely then, but very little has been done to implement them until recently. The necessity of developing a network of community clinics for early treatment as well as for follow-up of discharged patients is now recognized on a grand scale. The federal government has launched an extensive program to help and encourage the states to do this, and the development of local facilities is well under way. In spite of the commendable strides being taken in this direction, however, the total amount of money spent by Maryland and neighboring states is still only four to six percent of the state's mental hygiene budget—a ratio which falls far short of what this important expenditure should be.

In the recent past, administrators tended to take pride in how small a staff they required to run the mental hospitals and in how cheaply they could be hired. Fortunately, this type of economy is no longer considered a source of pride. The effectiveness of treatment must depend upon the number and quality of the hospital personnel, and the realities of manpower competition today are such that the upgrading of personnel, quantitatively and qualitatively, costs more money. This does not mean, however, that total costs are thereby increased. Numerous examples of recent experiences are now on record showing that substantial increases in personnel budgets are so effective in reducing average length of stay, and therefore total patient population, that total expenditures are reduced.

This finding suggests that state administrators should consider the costs of operating state hospital systems from two separate and independent viewpoints—that of the patient's "standard of living" and that of the "standard of therapeutic care." Increases in expenditure to improve the former are humane procedures which make for good public relations, but may have very little to do with the prime mission of restoring the patient to useful citizenship in his community; on the other hand, increases in expenditure for improvement of the latter, though less likely to serve a public relations purpose, are more effective in rehabilitating patients. The bulk of the expenditures which determine the level of patient care will be those spent to pay treatment personnel. At present this expense amounts to only about 10% of total state mental hygiene costs, the other 90% paying for goods and services which establish the "standard of living" of patients. In general hospitals, these two sets of costs are more nearly equal.

Let us now direct our attention to another subject of prime importance, and that is the community which the mental hospital serves. It is fashionable today to speak of "community psychiatry," and both the public at large and the professional mental health workers are joining forces to bring about a better level of cooperation. The American taxpayer is a much more sophisticated person today than he was in the past and can be expected to demand not only economy in the expenditure of his tax money, but also a high quality of service. He is very likely to realize that cheap roads, cheap schools, cheap teachers are, in the long run, more expensive than good roads, good schools, good teachers. If we were more diligent in educating Mr. Taxpayer and his rep-

resentatives to the state legislature, we could also expect him to demand good, not cheap, mental hospitals. He probably does not know, however, what makes good mental hospitals, since he is presented with few opportunities to visit them, or to study or appraise the effectiveness of their operation. He has been accustomed to think that the prime function of a mental hospital is much like that of a prison—to remove from ordinary society those people who exhibit unacceptable behavior. As long as he sees the mental hospital in this way, he is going to find very little reason to support increased appropriations for psychiatrists, psychologists, social workers or clinics.

It is encumbent upon us to teach the public that the people whose behavior is distressing either to themselves or to others need treatment and guidance, not isolation and abandonment. Once we achieve this educational objective, we can then show how a mental hospital would, ideally, serve as one resource in a broad network of treatment services which would also include community mental hygiene clinics, psychiatric services in general hospitals, school guidance programs and family welfare agencies, among others. As one of these resources, the mental hospital would be a place where a few patients might be sent, for brief periods of time, as part of a treatment plan and not as a frantic and desperate move to rid the community of one of its citizens. This philosophy has already received widespread acceptance in England, largely because that country could not afford the luxury of indefinitely segregating in its institutions the large percent of the population we segregate in ours.

We must ask the community to share with us some of the risks it is necessary to take in order to give patients a chance, outside of the hospital, to make it on their own. As we develop better treatment services, however, we can promise the community that the addition of local guidance facilities adds a new safety valve that was not available before. The essence of risk is that we might sometimes win and we will, inevitably, sometimes lose. When we lose, as we do, for example, when a discharged patient commits suicide, let us weigh this against the times we won before crying out in alarm to demand that every doubtful patient be locked up. Let us remember that before the advent of the surgical treatment of appendicitis no one died from operations, but a great many people died of untreated appendicitis. Now a few people die of operations, but practically no one dies of appendicitis. For psychiatric patients, the greatest losses are measured in the great number who spend nearly their entire lives in hospitals. To reduce the risk of these losses other risks must be taken, and these other risks, though they do exist to some degree, can be shown to be much smaller than they are thought to be.

The family physicians in the community are especially crucial in determining the course which mental health services will take in the future, since it is through them that patients get referred for care. Too often physicians have the idea, when they see a relatively minor psychiatric problem, that nothing special needs to be done, and so they give the patient a pat on the back and a bag of pills. If the troubling problem is not solved then, when it is minor, it is likely to grow to a major one and then, too often, frantic attempts are made to commit the patient to a mental hospital. Early recognition and effective, specific treatment can accomplish more than any other single move in preventing the development of the complex problems which become so difficult to solve when patients are hospitalized. Much of this can be done by the family physician himself without referral, but he will probably need a little more knowledge than his training has prepared him for, and perhaps more consultation.

In conclusion, let us focus on our reason for being here—the celebration of the 50th anniversary of the Eastern Shore State Hospital. As hospitals go, this is neither very old nor very young. The hospital has certain unique advantages which could be helpful in guaranteeing its future. In the first place, it is a small hospital, as state mental hospitals go. It is, in fact, of a size which is quite manageable, and let us pray that this never changes. Another advantage is its location. Not only is it placed in a lovely and attractive setting, but it is part of a particular kind of a community which offers substantial resources. The community is one of the oldest in the United States, with a long tradition of responsible community cooperation. The community is one which has pride in what it has and is therefore likely to take good care of what it has. Since the hospital is one of the things it has, it is highly likely that when the community is enlightened in ways it can serve the hospital, it will do so.

ALCOHOLISM AND THE LAW

The Alcoholic and Civil Law

THE REV. HARRY E. SHELLEY, LL B, TH B
Coordinator of Alcoholism Programs
Baltimore City Health Department

Our subject this evening is one that has both medical and legal implications and values. Alcoholism is a disease and, while there are many, many definitions of alcoholism and the alcoholic in the literature, all agree on at least one point and that is that alcoholism is characterized by the excessive use of alcoholic beverages. It is this excessive use of alcoholic beverages that frequently, quite frequently, brings the user into contact with the law.

In his book, "Liquor: The Servant of Man," Dr. Chafetz takes issue with the legal consequences of excessive use because he feels it is not a crime to be an alcoholic. If you have not read this delightful book, I certainly recommend it to you. You may recall the author acquired some notoriety a little while ago when he said we should teach our young people how to drink. Since that time we have heard all kinds of jokes about taking "Gin 102," "Martinis 305," and so forth, in school.

The chapter in Dr. Chavety's book of particular interest is entitled, "Is it a Crime to be Ill?" As you probably know, our law specifically states that "alcoholism is an illness and a public health problem, and the sufferer of alcoholism is recognized as one worthy of treatment and rehabilitation." This particular law has been on our statutes since 1960; it is Article 2C of the Annotated Code of Maryland; but, as my colleague, Mr. Embry, will no doubt point out later on, the same Code provides punishment for the alcoholic who manifests the symptom of his illness with public intoxication.

Many years ago, before there was a State of Maryland or a "great society" or even a country called the United States of America, the law had something to say about the excessive use of alcoholic beverages. Death by stoning was the prescribed penalty:

"If a man have a stubborn and rebellious son, which will not obey the voice of his father, or the voice of his mother, and that, when they have chastened him, will not hearken unto them: then shall his father and his mother lay hold on him, and bring him out unto the elders of his city, and unto the gate of his place; and they shall say unto the elders of his city, This our son is stubborn and rebellious, he will not obey our voice; he is a glutton and a drunkard. And all the men of his city shall stone him with stones, that he die: so shalt thou put evil away from among you; and all

Adapted from the two principal addresses in a panel discussion at the 168th Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, April 27, 1966. "The Alcoholic and Civil Law" is followed by "The Alcoholic and Criminal Law" by Robert C. Embry, Jr., LL B.

Israel shall hear, and fear."

In case you doctors and lawyers do not know your Old Testament as well as I think you do, that is from the Book of Deuteronomy. Since the time when it was written we have progressed somewhat in our methods of dealing with alcoholics and problem drinkers, for we no longer stone them to death, though we still place many of them behind stones and bars. More about this from Mr. Embry, however.

My assignment this evening is to discuss with you procedures for admitting or committing alcoholics to treatment programs in our State hospitals. Physicians should be familiar with these laws for two reasons. First of all, alcoholism is a medical problem and more and more the family physician is being drawn in to cope with it. Second, in the light of a recent court decision that Mr. Embry will discuss, the alcoholic is now being regarded as a patient and not as a prisoner.

A very excellent pamphlet for every doctor, and I might add every lawyer, to have on his desk is the *Directory of Specialized Services for Alcoholics in Maryland,* which is published by the State of Maryland Department of Mental Hygiene. It is my understanding that a copy of this directory was sent to every physician in the State at the time of publication. If you do not have a copy, however, you may obtain one by contacting Mrs. Gertrude Nilsson, coordinator of the Department's Services to Alcoholics. Her office is in the State Office Building at 301 West Preston Street in Baltimore.

There are four State hospitals in Maryland, all of which have specialized Alcoholic Rehabilitation Units for *males.* Now, I emphasize the word *males* because unfortunately the poor females are discriminated against. This is a man's world. Crownsville is the only one of the four State hospitals with a special unit for women. When a woman alcoholic goes to any of the other three for treatment, she is not sent to a special unit, but is placed in the general hospital group.

It is hoped that some day all of our State hospitals will have facilities to treat women in their programs for alcoholics. At present a woman alcoholic who has been in one of the hospitals without a special ARU for women is likely to rebel against a return trip to that hospital. Nor can she go to Crownsville unless she lives in the right zone. Patients are admitted to a given hospital according to the county or, in the case of Baltimore City residents, the postal zone in which they live. Details are presented in the directory that I mentioned.

There are six ways to gain admission of the alcoholic in one of the special Alcoholic Rehabilitation Units. The Annotated Code spells out the procedures in legal language, but I shall use the examples that are given in the directory because they are clear, concise and to the point.

First, if you have a patient who admits to his alcoholism and wants treatment in the State hospital program, the procedure is very simple. Let us say, for example, that your patient lives in postal zone 18. A glance at the directory will tell you that all patients from zone 18 go to Springfield State Hospital in Sykesville, Maryland. As the physician, you would call the admission service of that hospital for an appointment for your patient and send him there along with a certificate requesting his admission. A certificate from you is not required for this type of admission, but it is certainly helpful in geting your patients into the hospital.

The patient admitted under these circumstances must spend at least seven days in the hospital *after* notifying the hospital superintendent, in writing, of his intention to leave, so that he has at least seven days in the ARU. May I point out, however, that it is the administrative policy of some of our State hospitals not to admit patients under this provision on weekends or after working hours, that is, on Saturdays, Sundays or any time before 8:30 AM or after 5:00 PM. My advice to alcoholics would therefore be to avoid getting sick during these off-hours because they will have trouble getting into a hospital. Maybe some day we can do something about admission procedures, but this is today's administrative policy.

The **second** classification of patients differs from the first in that the family recognizes a patient's alcoholism and seeks treatment for him even though he may not be ready to seek it himself. As a matter of fact, many of the so-called "voluntary admissions" in the first classification are not too voluntary. The patient may have a wife pushing him in the back or a boss threatening him a bit. It boils down to the fact that many admissions of the first type are really involuntary.

When the admission is *admittedly* involuntary and the patient is committed by a member of his

family, the procedure is identical to that for voluntary admission except for the requirement that two doctors sign a form stating that the patient is an alcoholic requiring hospitalization. Before new legislation was passed in 1960, an alcoholic for whom treatment in a State hospital was sought was admitted as an insane person. Now, however, he may be admitted as an alcoholic.

Third, alcoholics in a psychotic episode, and alcoholics whose primary diagnosis is schizophrenia or some other mental disease, are admitted with signed forms declaring that the patient is insane. In the case of an emergency, such a patient may be taken to the hospital without an appointment. A minimum of three days in the hospital is required after the patient has sent a written request for discharge to the superintendent.

I have never been able to figure out why it is seven days for the plain old alcoholic, but three for others. If, however, the hospital physician believes that the patient may be a danger to himself or to others, he may request a sanity hearing to lead either to the discharge or to the court commitment of the patient.

All of these provisions are found in Article 59 of the State Code, entitled "Lunatics and Insane." The title probably reflects the fact that the word alcoholic was not in common use when the Article was framed.

Commitments Under Equity

The next three provsions for commitment are in Article 16, entitled "Chancery." In law there are two different kinds of courts, the law court and the chancery, or equity, court. If there is no remedy of law, a person can go to a court of equity, where the judge can give a remedy if there is no writ available. Proceedings under equity involve such things as divorce and alimony—and also alcoholics.

The **fourth** of the six means of committing an alcoholic to a State hospital ARU is by filing a petition, under oath, to a court of equity (in Baltimore City, the Circuit Court) declaring that the person is an "habitual drunkard." According to the provisions of the article on Chancery, the court then has the authority to institute proceedings against such a person. The procedure is outlined in detail in the law and I shall describe it in brief, but I should like, first, to point out a few things about this particular Article.

The term *habitual drunkard* is defined as follows: ". . . the words 'habitual drunkard,' as used in this section, shall be construed to embrace any person who may be habitually addicted to the use of alcohol, opium, cocaine, morphine or any other intoxicant."

You can see that *habitual drunkard,* by definition, covers a very wide area: it includes not only the addicted user of alcohol, but also those who habitually use these other drugs and intoxicants. And this is not a criminal procedure—Mr. Embry will be talking about the criminal end of it. This is not a criminal procedure and yet some of the language used in the statute sounds very much like criminal law. As was pointed out so aptly in the report of the Maryland Commission on Alcoholism published several years ago, the term "habitual drunkard" sounds very similar to the term "habitual offender," which is used in the criminal section of the law.

Furthermore, in commencing a procedure under the provisions of Article 16, the court issues a warrant for the person's arrest, and usually when we think of being arrested we think of a crime.

It is interesting to note that, under this section of the law, the person who is alleged to be an "habitual drunkard," incapable of taking care of himself or his property, has a choice. On the one hand, he may voluntarily enter any institution selected by the court, in which case the legal proceedings against him are dispensed with, he enters the institution "for a limited time," and he may appoint his own "committee." This constitutes a **fifth** means of commitment.

On the other hand, and here we return to the fourth means, if he does not voluntarily submit to these proceedings, the court appoints a committee for him and, with the approval of the court, the committee has the power to confine him in any suitable institution for such length of time as the court may in its writing approve. In addition, the period of involuntary confinement may be extended by his committee with the written consent of the court "for such period as may be necessary for his complete reformation."

I often wonder if any alcoholic ever gets "reformed." It is more appropriate to speak of a recovered alcoholic.

So far we have discussed the chronic alcoholic, or the habitual drunkard, incapable of taking care

of himself or his property, who is willing to go to a State hospital for treatment, and the one who is not willing to go, but gets there nontheless. Article 16 of the Code covers both of these. A third provision of the Article presents the **sixth** basis for commitment and applies to the alcoholic charged with a criminal offense. The Code states, "When any person charged with the commission of a criminal offense is shown to the satisfaction of the judge before whom he is brought to be suffering from acute or chronic alcoholism . . . the said judge may commit him to one of the State hospitals for treatment and observation, under such terms and conditions as he may determine."

Like Articles 59 and 2C, Article 16 uses, but does not define, the term *alcoholism*. It thus gives power to a judge, a man trained in the law, to decide whether the accused is or is not an alcoholic, the victim of an illness. As I look at these provisions, several questions come to my mind. First of all, if the judge sitting in criminal court invokes the provision of this particular section of the law, are the criminal proceedings against the person alleged to be an alcoholic postponed until after the treatment period at the State hospital? And if they are terminated, what then? Secondly, if the criminal proceedings are continued after the invocation of the section and the defendant is found not guilty, can the alcoholic defendant then be confined under this provision of Article 16 or is it necessary to utilize another provision?

According to the *criminal* section of the law, an alcoholic may be classified as a criminal, although his only crime is a public display of a symptom of his illness, and he can be put in jail; moreover, if he comes in five times in one year and they want to use the habitual offender statute, he can be put into jail for six months. In contrast, under the provisions of this *equity* section of the law, a defendant who may be guilty of a crime of violence, such as rape or murder, may be sent to a State hospital for treatment and observation.

Thus even cursory study of the laws of the State of Maryland as they relate to the alcoholic (especially in the light of what has happened recently) makes it quite evident that there is need for serious and deep study and for alterations of our laws if there is to be uniformity in principle and philosophy in our Code.

Maryland is, of course, not alone in this jumbled maze of legal inconsistencies, but it seems to me that, with the assistance of dedicated members of the Bar, members of the medical profession, and others interested in the problem of alcoholism, Maryland can be a pioneer and a leader in an area that has been too long neglected. I should therefore like to leave you with these questions: As doctors, how do you feel about this legal maze? And, as lawyers, how do you need the help of the medical men to help you unjumble it?

The Alcoholic and Criminal Law

ROBERT C. EMBRY, JR.
of the Maryland Bar
Executive Secretary, Mayor's Task Force on Alcoholism

As we shift our focus from civil to criminal law, we must beware lest we allow our emotions to supersede our reason. This is an area of extreme sensitivity and wide ramifications that involves us not only as lawyers and doctors, but also as concerned citizens. Furthermore, it is an area susceptible to the dogmatism of various ideological presumptions and, if we are to make any progress in understanding the complex relationship between alcoholism and the criminal law, we must be willing to adopt a flexible approach unfettered by preconceived slogans.

The interaction between criminal law and alcoholism has not produced much of intellectual interest over the centuries. Today criminal law deals with alcoholism in two ways—first, and most directly, by prohibiting any person from appearing drunk in public. Persons violating this prohibition are guilty of a misdemeanor and subject to a fine

and a jail sentence.* An habitual offender may be fined $100 and sentenced to six months in jail and, as you have been told, one achieves this status by being arrested five times within a twelve-month period.

This law is plainly inequitable. The persons arrested and prosecuted under its provisions are, almost without exception, poor. A seemingly properous member of the community, when found drunk in public, is put in a cab or taken home by a police officer. Though the law makes no distinction between the alcoholic who is so sick that he cannot control his actions and the otherwise healthy person who has had too much to drink, there is a distinction in practice. Oddly enough, the distinction is to punish the sick man while either ignoring or helping the healthy one.

This incongruity is founded on the pervasive attitude that alcoholism is sinful and evil, a reaction intensified by the offensive appearance and demeanor of an alcoholic. The gay and boisterous drunk has been glorified and honored by our art and literature, while the chronic alcoholic has either been ignored or locked away in some dark place where he will not offend the sensibilities of his more fortunate peers.

The second area of interaction between alcoholism and criminal law is less susceptible of definition, but much more serious in its effect. This situation arises when alcohol incites the drinker to behavior that, in contrast to public drunkenness, should clearly be labeled as criminal, eg, robberies, murders and rapes.

A further distinction can be based on the fact that alcohol acts as both a direct and an indirect causative agent. The relationship is *direct* when a person commits a crime while under the influence of alcohol. It has been known for centuries, even by lawyers, that excessive consumption of alcohol is often the immediate cause of a criminal act. Excessive consumption leads to a rejection of scruples and a discard of self-restraint. A recent study has revealed that in 1959, 80% of the inmates of the New York penitentiary had a drinking problem.

The changing legal reaction to situations in which alcohol is the direct cause of a criminal act demonstrates the changing attitude of society towards drunkenness. At first, the punishment was increased if the crime was committed while the defendant was intoxicated, with the explanation that two crimes had been committed, the second being drunkenness. As society progressed, this approach was gradually softened, but drunkenness was still not permitted to be raised as a defense because, as Blackstone put it, "One crime should not be allowed to privilege another."

Throughout the 19th century, it was the predominant view that to permit drunkenness to operate as a defense would be to permit a criminal to escape liability by drinking heavily before he committed a premeditated crime. Toward the close of the century, the argument was made that, since the drinking of an alcoholic was involuntary, the act resulting therefrom was involuntary and under the common law one cannot be punished for an involuntary act. This argument was rejected by use of the fiction that all drinking was legally "voluntary" since even alcoholics had at one stage drunk voluntarily.

An advance was made near the close of the century when it was held that, because a crime, by definition, required the existence of criminal intent, the jury may—in deciding whether the necessary intent was present—consider the fact that the defendant was drunk when committing the criminal act. In spite of this concession, drunkenness must be extreme before it will affect the verdict. As a rule, the only result of a showing of drunkenness is a mitigation of the punishment.

I believe that these unsympathetic practices were the product of a compromise by the judge between the knowledge that a drunk strongly resembles someone who is mentally deranged and the belief that all drunks *voluntarily* assume their inebriated condition. As you in the medical profession tell the lawyers more about alcoholism, it increasingly becomes another aspect of the question of criminal responsibility.

More important than situations where alcohol is a *direct* cause, are those where it acts *indirectly,* or environmentally, to produce anti-social behavior in others. It has been repeatedly demonstrated that a pattern of delinquent behavior is usually determined by the first few years of one's life: by the time a child is eight years old, most of his personality has been formed. Criminals are usually not the children of criminals, but rather are

*Art 27, sec 123, Md Code Ann (1957)

found to come from certain environments—broken homes and/or homes with slovenly and indifferent, indulgent or overly repressive parents. The broken home is the most fertile source of criminal behavior and such a home is often the product of excessive drinking. Furthermore, alcoholic parents usually are slovenly and possess intense anti-social views. To these factors can be added the obvious one of reduced income and resulting poverty that can often be traced to alcoholism.

The relationship between criminal law and alcoholism is therefore threefold: alcoholism is a crime when evidenced in public; it directly causes many crimes of violence: and it contributes to the formation of an environment which produces criminal personalities.

Such, at least, has been the relationship until very recently. At the present time, alcoholism is no less a contributor, direct and indirect, to crime. No longer, however, is public evidence of alcoholism clearly a crime. In fact, in five of the 50 states, including Maryland, it is clearly *not* a crime. What has happened?

What has happened is that a man named Joe Driver, through his lawyers, had the audacity to demand that the law adopt a rational approach to the problems of alcoholism. As often occurs in the law, the single-mindedness of one man, convinced of the rightness of his cause, has worked a revolution.

Mr. Driver was arrested in Durham, North Carolina, in December, 1963, and charged with being drunk in public. He admitted the truth of the allegation and was sentenced to two years in jail. Aside from the severity of the sentence, this occurrence is hardly noteworthy because the same occurrence could be witnessed in any police court in the country.

Joe Driver was no stranger to the process. He was first arrested for public intoxication at the age of 24 and had been convicted of that offense more than 200 times since then. By the age of 59 he estimated that he had spent two-thirds of his adult life in jail as the direct result of alcohol. At his trial, although he admitted he had been drunk in public, he advised the court that he was a chronic alcoholic and asked that he be given medical treatment rather than a jail sentence. The request was ignored and the sentence was routinely announced. Ordinarily the matter would have ended there.

Joe Driver, however, was aware of a Supreme Court decision handed down the preceding year, which seemed to substantiate his claim that he could not be punished for public drunkenness. In that decision the Court reversed the state decision in the case of *Robinson vs California,* wherein Robinson was convicted under a statute that punished drug addiction. The reversal was based on a new doctrine.

As you know, our Constitution was amended before ratification by the addition of eleven provisions. In this so-called Bill of Rights there are protections against the federal government's interference with speech and religion, and there are guarantees of due process and jury trials. Shortly after the Civil War, these restrictions on governmental action were extended, by the 14th Amendment, to apply to the states as well as to the federal government. One of the original amendments, the Eighth, forbids the government's imposing any cruel and unusual punishment. In previous decisions this Amendment had been interpreted as prohibiting obviously cruel punishments, such as torture, or those greatly disproportionate to the crime, such as a fifteen-year sentence to hard labor for petty theft. The drug addict argued that the amendment also forbade the punishment of a sick man for being sick. The Supreme Court agreed.

To be successful in his defense it was necessary for Joe Driver to extend this new concept even further. The *Robinson* opinion made it unconstitutional to punish a condition, drug addiction, that medicine had described as a disease. While it was true that alcoholism is also a disease, Driver was not convicted for being an alcoholic. He was convicted for being drunk in public, the manifestation of a condition rather than the condition itself. Driver was not daunted by this difference. He argued that if North Carolina could not punish him for being an alcoholic, it could not punish him for a necessary product of that condition, such as public drunkenness.

The North Carolina Supreme Court rejected this argument in a brief opinion that contained no explanation of the court's reasoning. Up until recent times the matter would have ended at this point. Thirty years ago, however, it was decided that the federal courts, when petitioned for a Writ of Habeas Corpus, could call upon the state to

show that it was not holding a particular prisoner in violation of the protections set forth in the federal Constitution. Aware of this alternative, as are most persons who frequent our jails, Joe Driver petitioned the federal district court of North Carolina for such relief.

It might be noted here that this case offers a prime example of why our federal courts have ruled on so many matters which were formally the concern of the states. When Joe Driver presented his unique argument to the North Carolina state court it was disposed of in a short paragraph, with no attempt made to confront the very serious issue raised by the appellant. State courts have continually refused to concern themselves with the affronts to human dignity often found in our criminal law. As a result the federal courts, after continuous state procrastination, have been forced to fill the vacuum. While the preservation of strong state governments is important, of greater import is the need to prevent undue public imposition on any citizen. As with many other public problems, when state governments assume their proper responsibility the power they have lost to the federal government over the last three decades will return to its original and most efficient repository.

Let us get back to Joe Driver, however. His argument was accepted by the Federal Court of Appeals for the Fourth Circuit, which includes Maryland as well as North Carolina. For the first time in recorded history a court ruled that an alcoholic could not be punished for public intoxication. As you can well imagine, this decision has raised as many questions as it has answered.

In the limited area of alcoholism, the grounds of the decision are somewhat misleading. It is not the placing of a destitute alcoholic in jail that is cruel, for there he receives shelter, food and some medical attention. What is cruel is that our rich society allows this person to continue to degenerate without doing anything to delay the process. It is not enough then to leave the alcoholic on the street, for this is the really cruel possibility. Fortunately, the jail and the street are not the only alternatives. We must fashion some positive program which will break the circle of despair and enable these miserable people to regain their self-respect. The particulars of such a program have yet to be developed and its formulation promises to be one of the most complex and frustrating tasks imaginable, yet it must be undertaken. Neither law nor medicine has the answer, and it is unlikely that either will find it alone, but I am confident that an alliance of the two disciplines can work wonders.

The implications of the *Driver* decision are important to us not only as lawyers and doctors, but as citizens who should be aware of, and participating in, what promises to be a revolutionary change in our society's laws. Fundamental decisions must be made about our philosophical and legal assumptions. This task must not be left to lawyers.

The particular assumption challenged in this case is that of free will. If reduced to its basic elements, and if some glaring exceptions are summarily ignored, Anglo-American law establishes as a prerequisite to criminal liability that there be both an act and a conscious state of mind. This state of mind is called *mens rea*, or a guilty mind. This mental state is required because we have assumed that man makes a free choice when he acts and if that act is socially undesirable, the man is deserving of punishment.

The *Driver* opinion focused on the retributive and deterrent aspects of criminal law, the most primitive justifications. Because retribution in the case of an involuntary act was viewed as unfair, and deterrence as impossible, punishment of the publicly drunk alcoholic was forbidden. This reasoning leads to two observations.

First, imprisonment can no longer be justified on the grounds of either isolation or reformation, the other two conceivable justifications. It had been previously thought that either was sufficient to warrant incarceration. An alcoholic can no longer be jailed just because he is deemed repulsive or dangerous, or just because someone believes he should be cured of an illness. Alcoholics can no longer be dealt with by an institution that assesses moral guilt; their treatment cannot involve the criminal courts. This result might not be applauded when we sit down to think about how the machinery is to be set up to get alcoholics off the street and into a program that offers some hope of success.

The **second** observation is that other areas of the law are subject to a much needed reappraisal. To begin with, how should the courts dispose of a case where the defendant is an alcoholic accused of drunken driving? If you answer that the alco-

holic was not compelled by his sickness to drive while inebriated, remember that Joe Driver was not compelled to be in public when he was "under the influence." The fact is that once an alcoholic begins to drink, an act which is involuntary, he no longer is conscious of what he is doing, with the result that any subsequent action is to some degree the product of his sickness and something for which he arguably may not be held morally responsible. Consider further the alcoholic who steals to obtain money to buy a drink. I think you can see how difficult it is to draw the line where criminal liability begins.

Analogous questions arise in other areas where an admitted illness gives rise to socially undesirable acts. Might not this opinion be read as requiring us to re-examine our barbaric and narrow-minded attitudes toward homosexuality? But if we do so, are we prepared to excuse a homosexual who perpetrates vulgar public displays? Again, what about the narcotic addict who in order to service his needs sells dope to others? These ramifications are being explored. Recently, a gentleman in Washington, indicted for passing bad checks, pleaded that he did it to obtain money to buy liquor to service his alcoholism. Though no decision has yet been reached, it is noteworthy that the defense was not rejected out of hand.

The line of analysis may be further extended. The Director of the Federal Bureau of Prisons recently predicted that in ten years the war on poverty would reduce our prison population by 50%. Put another way, his position is that there are certain conditions external to man that destroy his free will and bring about criminal acts. This idea is not new, of course, but its implications have never been honestly confronted. Recently, Sheldon Glueck, at Harvard Law School, isolated five environmental factors that could be used to pinpoint those children who would commit a serious crime before reaching adulthood. Predictions based on these factors had proved accurate in nine out of ten cases. This indicates that all criminal activity is to some degree as involuntary as the public drunkenness of an alcoholic. It also indicates a crueler irony than exists with respect to alcoholism: unlike the latter illness, which may be caused by a person's physical or mental makeup, the environment-oriented illness that produces most other crimes is in large part caused by the same insensitive society that later seeks to punish the product of the illness. How then can the law, how then can we as citizens, answer the lawbreaker who cries that it was known, or could have been known, at the time he was five years old that he would commit a crime, when we have done nothing about it? The answer of an earlier age would have been that they had neither the knowledge to make such a prediction nor the resources to correct the harmful environment. Neither of these answers may be honestly given today.

A warning must be raised against proceeding too rapidly with a brave-new-world approach that turns all persons who commit anti-social acts over to members of your profession, there to remain until they are medically determined to be no longer dangerous. The average offender would much rather suffer a definite prison sentence than indefinite commitment to a medical institution. I think the danger implicit in shoving the complete responsibility in this area on your shoulders is readily apparent.

In pointing out the potential ramifications of the *Driver* decision, I do not mean to comment on their validity. Rather my desire is only to indicate that we are entering a difficult but exciting period. As noted by Chief Justice Warren in his recent speech at the University of Maryland Law School, our society is now at the stage where it can afford to do some fresh rethinking of our assumptions in the area of criminal responsibility. In doing so, however, we must have the courage and commitment to meet the challenges of the answers. Such a challenge is exemplified by the alcoholic. Now he can no longer be jailed—an advance, no doubt. But have we really progressed if he is returned to the streets uncured because there is no non-penal facility that will take him and there is no medical program that offers a possibility of rehabilitation and cure?

May I close with the personal observation that, no matter how vexing the complications of this new trend in the law prove to be, they must be confronted and overcome if we are to continue to progress toward that society to which we have committed ourselves in the oaths of our respective professions.

COXSACKIE VIRUS GROUP A, TYPE 7 INFECTION IN MARYLAND

STUART H. WALKER, MD
YASUSHI TOGO, MD
MARGARET M. KEEFER

Coxsackie virus Group A, Type 7 has been demonstrated to produce distinctive neuronal damage in man and monkeys.[1, 2] Attention was called to this property by Russian workers who isolated this agent from patients in an outbreak of clinical paralytic poliomyelitis in 1950.[3] It has since been isolated from patients with lower motor neuron disease in the United States[4, 5] and Scotland.[6] The histological appearance of the disease produced in monkeys by this agent resembles mild paralytic poliomyelitis, but is characterized by involvement of the corpus striatum and the temporal and occipital lobes of the cerebral cortex which are rarely, if ever, involved in poliovirus infection.[7, 8] Because of these unusual features the isolation of Coxsackie virus Group A, Type 7 in Maryland warrants this report.

Report of Case

An eight-year-old white boy entered Mercy Hospital, Baltimore, on June 23, 1964, because of headache and back pain for one day. Two days prior to entry he was less active and complained of slight headache. Nuchal rigidity, positive Kernig's and Brudzinski's signs, tachypnea, hyperactive right patellar reflex response, and a temperature of 102.6 F (39.2 C), were detected at the time of entry. The clear spinal fluid revealed 182 white cells per cu mm (100% lymphocytes) with a total protein concentration of 54 mg and a sugar concentration of 58 mg per 100 ml and chloride concentration of 118 mEq per liter. Examination of the blood revealed a white cell count of 8,450 per cu mm, with 65% neutrophils, 33% lymphocytes and 2% monocytes. No organisms were isolated from blood or spinal fluid obtained at this time, the urine was normal, a slide agglutination test for Leptospira was negative and radiographic examination of the chest revealed no abnormalities.

On the day after entry, headache was much decreased and nuchal rigidity was much less. The temperature continued at approximately 101 F to 102 F (38.3 C to 39.4 C) until the third hospital day by which time all signs and symptoms of meningeal irritation had disappeared. The transient alteration in right patellar reflex response disappeared on the second hospital day and no other focal neurological abnormalities were detected. The patient was discharged from the hospital six days after entry and no residual neurological deficits have been subsequently detected.

Comment

Throat swab and rectal swab specimens were collected shortly after admission and brought to the Division of Infectious Diseases, University of Maryland School of Medicine. The specimens were inoculated into several tissue culture systems and litters of one-day old suckling mice, for virus isolation attempts. Rectal swab specimens yielded classical flaccid hindleg paralysis of suckling mice in seven days and subsequent passages of the carcass suspension regularly produced the same

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disease. The third passage material was employed for identification which was carried out by the neutralization technique using type-specific Group A Coxsackie virus antisera. The isolate was identified as Coxsackie virus Group A, Type 7.* The throat swab specimen did not yield virus. Virus isolation attempts in tissue culture systems were all negative. Neutralizing antibody titers in acute phase serum (obtained on the second day of disease) and late convalescent serum (4½ months after the onset of the disease) against 100LD50 of the patient's infecting virus were 1:40 and 1:160, respectively.

Summary

A laboratory-confirmed infection by Coxsackie virus Group A, Type 7 producing the clinical picture of aseptic meningitis is presented. The recognition of infection with this agent is important since its neurotropic behavior seems to lie between the other Coxsackie viruses and the polioviruses. It is capable of producing mild to moderate paralytic poliomyelitis and may account for an increasing proportion of patients with this diagnosis in areas where the population is well protected against poliovirus infection.

*This finding was confirmed at the Communicable Disease Center, Atlanta, Georgia.

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SEVERE PULMONARY EDEMA AND CONGESTION FOLLOWING THORACENTESIS IN A PATIENT WITH SEVERE AORTIC STENOSIS

CONSTANTINOS DRITSAS, MD,
C. THOMAS FLOTTE, MD

Removal of fluid from body cavities is not always an innocent procedure. Collapse due to sudden sodium depletion following abdominal paracentesis has been reported, and thoracentesis has at times been attended by such systemic symptoms as circulatory collapse and pulmonary edema.

Therapeutic misadventures of this type probably occur more often than they appear in the literature. Within the last six years only one case of acute pulmonary edema subsequent to thoracentesis was found.[1]

From the Department of Surgery, University of Maryland School of Medicine, and Maryland General Hospital, Baltimore, Maryland.

Report of Case

LKL, a 71-year-old white woman known to have had hypertension and "rheumatic heart" for many years, was admitted to the Maryland General Hospital with the chief complaint of shortness of breath. During the six months prior to admission she had had episodes of dyspnea and ankle

edema. The dyspnea was at first exertional, becoming progressively worse until two days before admission at which time she was dyspneic even at rest. She had had bouts of angina pectoris for many years. On admission the patient was dyspneic. The blood pressure was 140/90, pulse 160, repirations 35, temperature 101 F (38.3 C). The breath sounds were diminished at both bases and there was clinical evidence of bilateral hydrothorax. The heart was enlarged to the left and a grade III systolic murmur was heard in the aortic area with radiation to the neck. An apical systolic murmur was present. The liver was felt three fingerbreadths below the right costal margin. The EKG showed supraventricular tachycardia with left ventricular hypertrophy and strain. The patient was placed in an oxygen tent and treated with mercurial diuretics, morphine sulfate 10 mg and phenobarbital 15 mg. Two hours following admission, a thoracentesis was done on the left side, with removal of 1000 cc of clear fluid. Immediately thereafter the patient went into acute pulmonary edema and expired approximately one and a half hours following the thoracentesis.

The principal findings on post mortem examination were related to the heart and lungs. The lungs showed severe edema and congestion. The congestion was especially pronounced in the left lung, which weighed 475 gm; the right lung weighed 375 gm and showed moderate edema. The left ventricle showed hypertrophy of the prestenotic type. The aortic valve was stenotic due to marked calcific sclerosis with calcium deposits in the sinuses of Valsava, which were actually filled (Fig 1). The mitral cusps also showed sclerosis, involving the ventricular surface. The coronary vessels showed minimal arteriosclerotic changes. The anterior descending and right coronary arteries were very small in size. Microscopic examination of sections from the lungs revealed extensive edema and congestion, and large areas of actual hemorrhage into the alveolar spaces especially severe in the left lung (Fig 2).

Comment

The rapid sequence of events, supported by the pathologic evidence in this case, suggests a cause and effect relationship between the thoracentesis and the subsequent acute pulmonary edema.

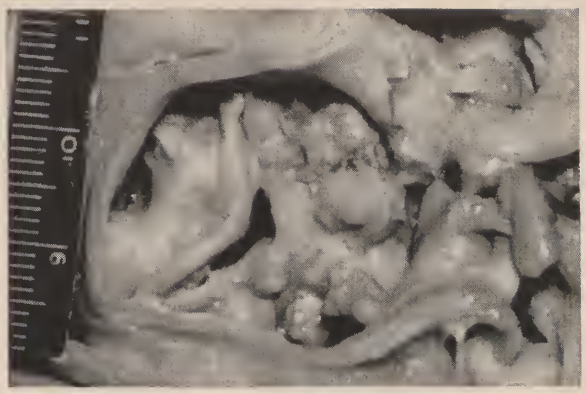


Fig 1
Aortic valve—extraventricular view
(Note the severe stenosis with calcification of the leaflets.)

It has been estimated that the blood volume in the pulmonary capillaries should be 75 cc at rest and up to about 100 cc during exercise. This increase is the result of increased output of the right ventricle. Obviously it is the response of the left ventricle, which increases its output, that prevents pulmonary congestion. It is conceivable that removal of 1000 cc of fluid from the thoracic cavity should have resulted in an increase of the pulmonary capillary blood volume by two mechanisms:

(1) Increase of the right ventricular output (active mechanism).

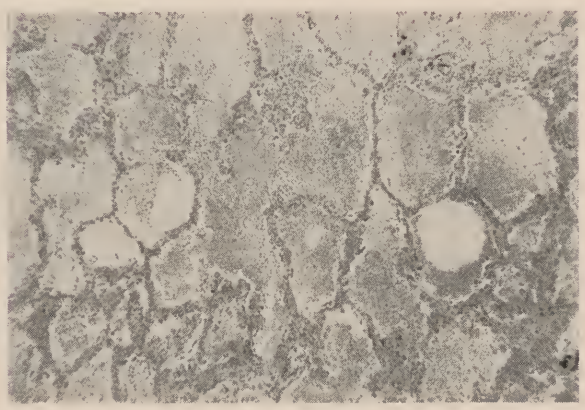


Fig 2
High power photomicrograph showing pulmonary edema and congestion
(Note the intra-alveolar hemorrhage.)

(2) Expansion of the pulmonary capillaries, now under the continuous strain of the negative intrathoracic pressure (passive mechanism).

The balance in the cardiopulmonary system is thrown off at this point, and it is now up to the left ventricle to make the pertinent corrections. The only way by which the left ventricle can accomplish this is by increasing its output. It is, however, both experimentally and clinically established that a heart with aortic stenosis shows a very slow or no response (depending on the degree of stenosis) in situations in which demands upon it are increased. The most important disturbances of the circulation in aortic stenosis are related to (a) slow emptying of the left ventricle, (b) inability of the left ventricle to increase its output quickly, (c) inadequacy of coronary blood flow. Left ventricular output is relatively fixed in severe aortic stenosis and stroke output rarely rises with exercise. The left ventricular pressure may exceed 250 mm/Hg during isometric contraction; this and the prolongation of the systolic phase interfere with coronary blood flow, with further limitation on the ability of the left ventricle to increase its work.

The case presented may be compared with cases of sudden pulmonary edema developed on the operating table during pericardiolysis for constrictive pericarditis, when the procedure is inadvertently started over the right ventricle.

Summary

A case is reported of fatal pulmonary edema and congestion, following thoracentesis in a patient with severe aortic stenosis and chronic heart failure. Evacuating thoracentesis in patients with aortic stenosis should be undertaken with caution. To provide time for adjustment, small amounts should be removed at intervals. Rotating tourniquets to trap blood temporarily in the periphery, beginning simultaneously with thoracentesis and gradually discontinued after the thoracentesis has ended, may be protective. Acute pulmonary edema and congestion will not, as a rule, develop in all cases with aortic stenosis undergoing thoracentesis. Degree of stenosis, grade of cardiac reserve, and adequacy of coronary blood flow are determining factors in a way that makes the case unpredictable. The possibility of therapeutic misadventure, however, should be borne in mind, and caution should be exercised in all cases.

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STUDY OF INFORMATION-GATHERING PATTERNS

A comprehensive study directed toward identifying ways in which medical scientists seek information in their own working environments is one of several projects in information science receiving Public Health Service support, according to Marjorie P. Wilson, MD, associate director for Extramural Programs of the Public Health Service's National Library of Medicine.

The study, for which the National Library of Medicine has made a grant of $38,653 to Northwestern University, is entitled "Experiments on Information Environments of Researchers." Principal investigator is Albert H. Rubenstein, PhD, professor of industrial engineering and management sciences.

The project is aimed also at determining scientists' information needs and matching those needs to a comprehensive range of information services; measuring the impact of new information services; and comparing the information-gathering patterns of several biomedical disciplines.

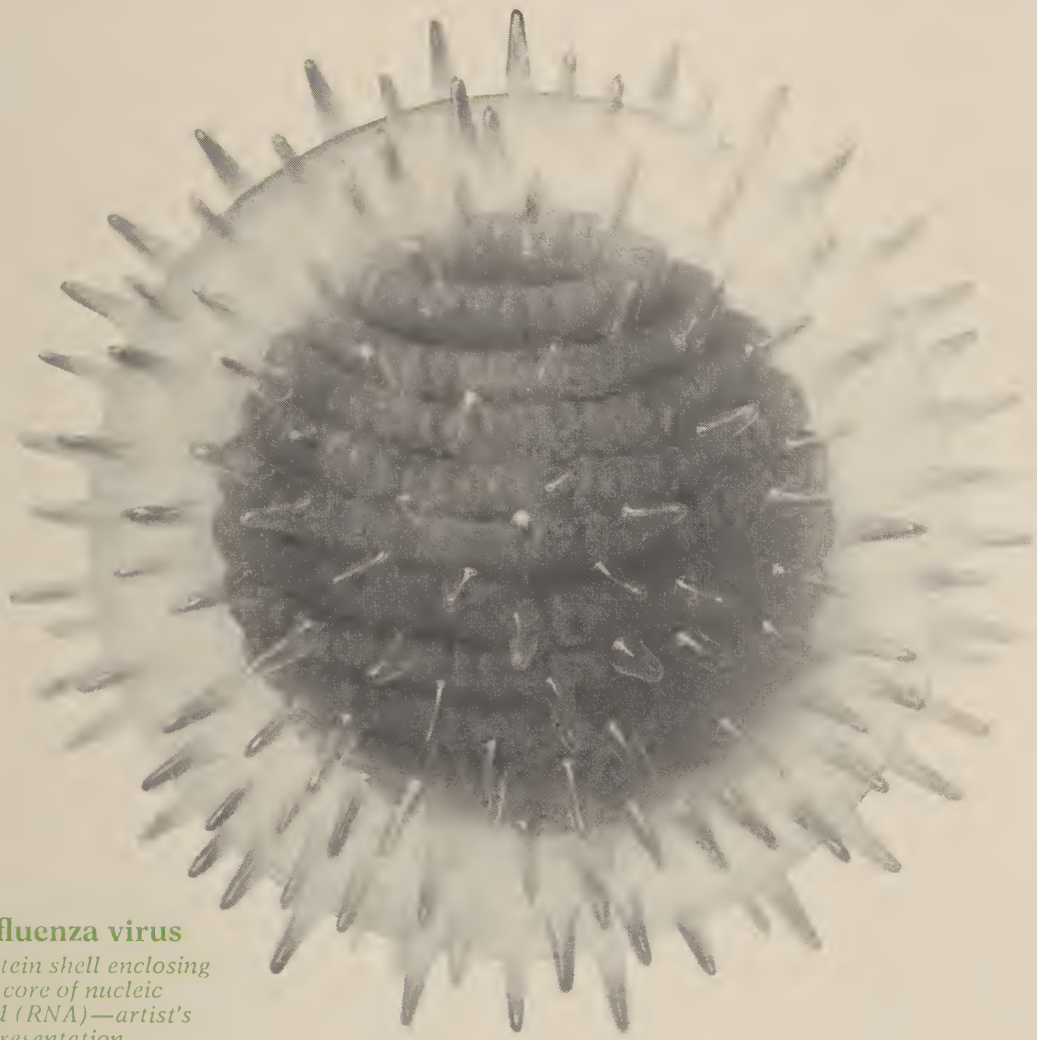
Public Health Service news release, Dec, 1966.

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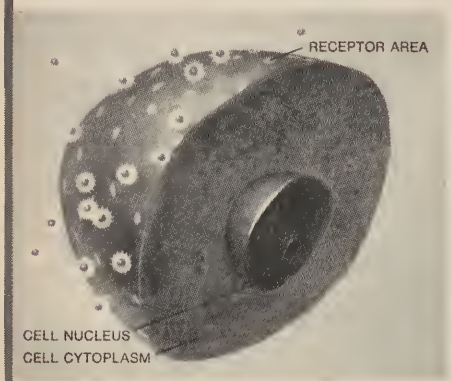
...may be particularly useful during outbreaks or epidemics and for high-risk patients in whom the occurrence of influenza A_2 is especially hazardous.

...a high degree of safety in clinical use.

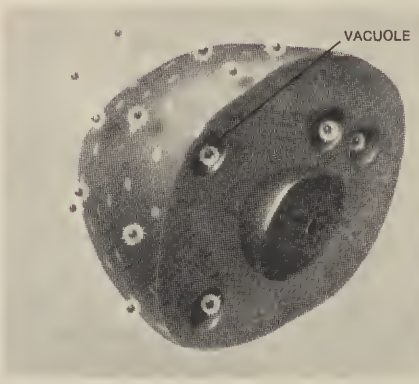
...simple once daily or b.i.d. dosage.

The mode of action of Symmetrel®

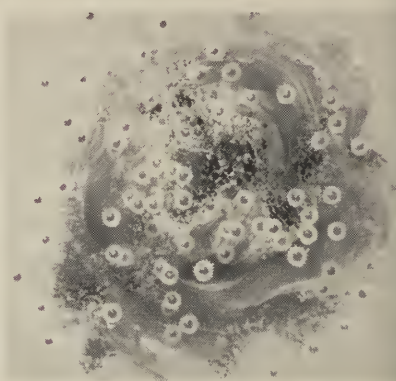
How the influenza virus invades and destroys the untreated cell



1 Viruses outside the cell attach themselves to specific cell receptor areas

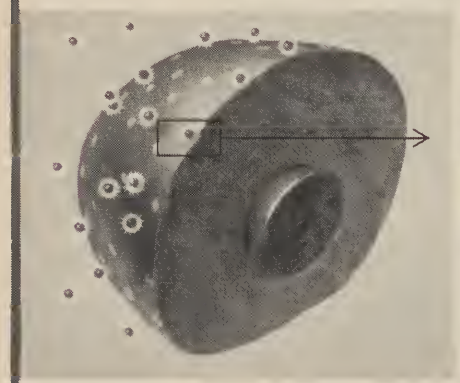


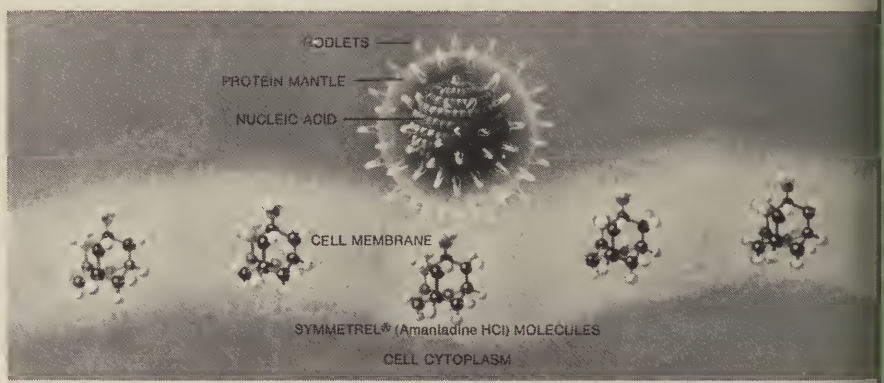
2 The virus is incorporated into a vacuole within the cell. From this vacuole the virus nucleic acid passes into the cell cytoplasm



3 The virus nucleic acid then directs the cell to produce both new virus nucleic acid and virus protein coat material which aggregate to form new virus particles. This process leads to the release of new virus particles and eventual destruction of the cell

How Symmetrel® (Amantadine HCl) prevents virus invasion[1]





Our current knowledge leads us to believe "Symmetrel" acts as a molecular barrier to influenza virus penetration. Shown here in a greatly enlarged section, "Symmetrel"—located at the cellular membrane—effectively prevents (blocks) virus penetration. Thus, "Symmetrel" does not directly destroy the virus particle but acting as a virostat prevents the cycle of virus penetration, virus replication, and cell destruction that is characteristic of virus invasion of animal cells (tissue). *Artist's conception based on current scientific knowledge.*

1. "Mode of Action of the Antiviral Activity of Amantadine in Tissue Culture", Hoffmann, C. E.; Neumayer, E. M.; Haff, R. F.; and Goldsby, R. A., Journal of Bacteriology *90*,623 (1965).

afety of Symmetrel® Confirmed. When used as indicated, is generally well tolerated. No kidney, ver, bone marrow, or hematological disturbances have been observed.

rescribing Information

ndications: "Symmetrel" is indicated for the preven- on (prophylaxis) of influenza A_2 in persons of all age oups. Early use is recommended, preferably before as soon as possible after actual or suspected con- ct with individuals suffering from influenza A_2. Symmetrel" should especially be considered for gh influenza-risk patient groups such as those suf- ring from chronic debilitating diseases and elderly rsons.

ontraindications: Not indicated for the prevention influenzal or respiratory illness other than influ- za A_2 or for the treatment of established disease.

arnings: Administration to patients with central rvous system disease, particularly geriatric patients th cerebral arteriosclerosis, and patients with a story of epilepsy or other "seizures," requires strict bservation for possible untoward effects (see Ad- rse Reactions). Patients taking psychopharmaco- gic drugs, central nervous system stimulants, or coholic beverages should be observed for possible idence of intolerance. Those patients who experi- ce central nervous system effects or blurring of sion should be cautioned against driving or working situations where alertness is important.

No teratogenic effects have been seen in reproduc- e studies in rats and rabbits. Studies in pregnant omen have, however, not been done and use of this ug in women of childbearing age should be under- ken only after weighing the possible risks to the tus against benefit to the pregnant patient. It should t be administered to nursing mothers since it is not own whether the drug is secreted in the milk.

ecautions: Ineffective against bacterial infections. tients should be observed for idiosyncratic reac- ns as with all new drugs. Geriatric patients with e-existing serious medical illnesses with mental or ysical deterioration should be followed carefully edically while taking "Symmetrel." (See Adverse actions.)

verse Reactions: With higher than indicated doses anifestations of central nervous system effects such as nervousness, insomnia, dizziness, lightheadedness, drunken feeling, slurred speech, ataxia, inability to concentrate and some psychic reactions including depression and feelings of detachment were seen. Occasional blurred vision was reported at higher doses. Some of the milder and less pronounced symptoms above have been reported in a small number of patients taking the recommended dosage of 200 mg per day. Those were mostly transient and disappeared with continued administration of the drug. Some geriatric patients developed paranoid or hallucinatory behavior and became unmanageable while taking 200 mg daily. Medically unselected seriously deteriorated geriatric patients showed poor clinical tolerance after several weeks of daily dosing with 200 mg per day. One elderly patient with a history of prior cerebrovascular accident developed visual hallucinations and grand-mal convulsions while on drug at 800 mg per day. Some cases of dry mouth, gastrointestinal upset and skin rash and rarely, tremors, anorexia, pollakiuria, and nocturia have been also reported.

Safety: When used as indicated, is generally well tolerated. No kidney, liver, bone marrow, or hematological disturbances have been observed.

Dosage: *Adults:* Two 100 mg capsules (or 4 teaspoonfuls of syrup) as a single daily dose or the daily dose may be divided into one capsule of 100 mg (or 2 teaspoonfuls of syrup) twice a day.

Children: 1 yr.—9 yrs. of age: Calculate total daily dose on the basis of 2 mg to 4 mg per pound of body weight per day (but not to exceed 150 mg per day). Daily dose, given as the syrup, should be given in 2 or 3 equal portions.

9 yrs.—12 yrs. of age: Total daily dose 200 mg given as one capsule of 100 mg (or 2 teaspoonfuls of syrup) twice a day.

How Supplied: *Capsules:* Bottles of 100. Each red, gelatin capsule contains 100 mg amantadine HCl.
Syrup: Bottles of 1 pint. Each 5 ml (1 teaspoonful) contains 50 mg amantadine HCl.

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arrest diarrhea

in • gastroenteritis • acute infections



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diphenoxylate hydrochloride ..... 2.5 mg.
(Warning: May be habit forming)
atropine sulfate ..... 0.025 mg.

Effectiveness: Lomotil possesses a unique degree of effectiveness in both acute and chronic diarrhea.

Convenience: Lomotil is supplied as small, easily carried, easily swallowed tablets and as a pleasant, fruit-flavored liquid.

Versatility: The therapeutic efficiency, safety and convenience of Lomotil may be used to advantage alone or as adjunctive therapy in diarrhea associated with:

- **Ulcerative colitis**
- **Acute infections**
- **Irritable bowel**
- **Regional enteritis**
- **Drug therapy**
- **Food Poisoning**
- **Functional hypermotility**
- **Malabsorption syndrome**
- **Ileostomy**
- **Gastroenteritis and colitis**

Dosage: For correct therapeutic effect—Rx correct therapeutic dosage. The recommended initial daily dosages, given in divided doses, until diarrhea is controlled, are:

Children: Age	Total Daily Lomotil Dosage	Lomotil Liquid Dosage (Each teaspoonful [4 cc.] contains 2 mg. of diphenoxylate HCl)
3-6 months	3 mg.	½ tsp. 3 times daily
6-12 months	4 mg.	½ tsp. 4 times daily
1-2 years	5 mg.	½ tsp. 5 times daily
2-5 years	6 mg.	1 tsp. 3 times daily
5-8 years	8 mg.	1 tsp. 4 times daily
8-12 years	10 mg.	1 tsp. 5 times daily

Adults: 20 mg. (2 tsp. 5 times daily or 2 tablets 4 times daily) Based on 4 cc. per teaspoonful. Maintenance dosage may be as low as one-fourth the initial daily dose.

Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is a Federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be kept out of reach of children since accidental overdosage may cause severe respiratory depression. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

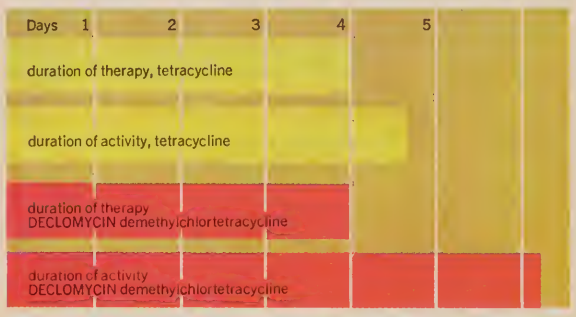
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Contraindication—History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort.

Precautions and Side Effects—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg; *Tablets:* film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

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Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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COMPONENT MEDICAL SOCIETIES

FREDERICK COUNTY

The Frederick County Medical Society held its annual elections on December 20, 1966, at the Hotel Frederick. The following were elected to office for 1967:

President: **Richard L. Fruth, MD**
President Elect: **Rex Martin, MD**
Secretary: **Robert J. Thomas, MD**
Treasurer: **Richard C. Reynolds, MD**
Executive Committee Member (for 3-year term): **Frank Damazo, MD**
Delegates: **T. D. Reid, MD**
Charles Wright, MD
Alternates: **Robert J. Thomas, MD**
John Teske, MD

Robert S. Turner, MD

MONTGOMERY COUNTY

John O. Robben, MD, president of the Montgomery County Medical Society, has announced the society's participation, under contract with the US Public Health Service, in a new study of the use of nursing homes as Extended Care Facilities under the Medicare Act.

The society's two-fold task in this project is to coordinate activities involved in the flow of patients from hospital to Extended Care Facility to nursing home (and/or, if developments permit, to the patient's home) and to make continuing utilization reviews of the Extended Care Facilities in the County. A coordinator has been employed to maintain control records of patient flow, and Utilization Review Committees are being formed to review both individual long-term patients and the Facilities providing care and services.

George Sharpe, MD
Chairman, Medicare Coordinating Committee

WASHINGTON COUNTY

The Washington County Medical Society met at the Venice Restaurant on Thursday, January 19, 1967. Despite a snowy beginning, the weather behaved and we had an excellent turnout. The scientific portion of the meeting was conducted by **Robert J. Hall, MD,** a colonel in the Army Medical Corps and presently chief of cardiology at Walter Reed Hospital. His topic was "Deceptions in Cardiology."

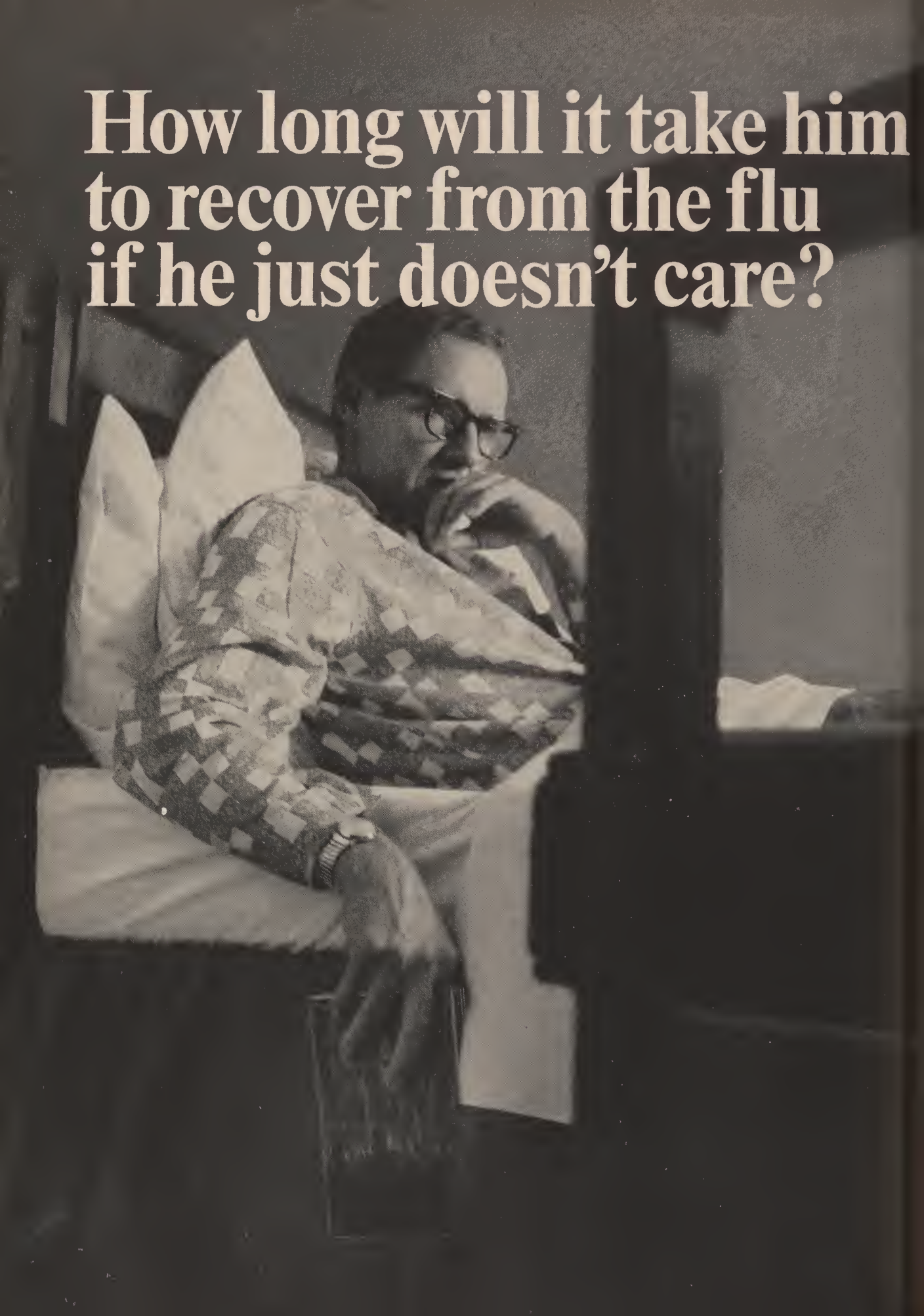
* * * * *

Members of the Executive Committee of the Washington County Medical Society, and members of the society's Public Health and Legislation Committee, met on January 12 with State Senator George Snyder, the Delegates from Washington County, and **John Sargeant,** executive secretary of the Medical and Chirurgical Faculty. During lunch a very informal discussion took place between the physicians and legislators, with Mr. Sargeant supplying pertinent information from the Faculty office. Each group seemed to enjoy the opportunity to meet the other group and both were well represented. Senator Snyder stressed the fact that it was important for physicians to be aware of what is going on, and to be willing to exchange ideas with their representatives.

* * * * *

Richard T. Binford, MD, has now assumed the presidency of our county medical society and has been busy naming committee chairmen and getting things under way for the coming year. Our best wishes to him for a good year in office.

John W. Clark, MD
Secretary


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*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.

Indications: 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

Contraindications: As with other drugs with CNS stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive compulsive states.

Side effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

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Pediatrics

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WILSON L. GRUBB, MD, Chairman

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The Physician and School Health

FRED J. HELDRICH, MD
Chairman, Committee on School Health
Maryland Chapter, American Academy of Pediatrics

Anyone caring for children must of necessity be concerned with the broad area of school health. Despite the many sub-divisions of school health that could be enumerated, the problem basically involves evaluating, protecting and promoting the health of school children and, in addition, providing for them a sound health education curriculum. Working towards this end for the child's benefit are three major groups: parents, educators, and the medical profession. Each of these groups is aided and abetted by other "special interest groups." This is especially true of the medical profession, which is helped by such groups as the Tuberculosis Association, the Heart Association, and the Society for the Prevention of Blindness. It is important that the three major groups assume primary responsibility in this area.

As stated by the Committee on School Health of the American Academy of Pediatrics, the objectives of any school health program fall into three broad categories: health appraisal, follow-up, and parent education and counseling.[1] Perhaps a fourth might be added—student education and counseling. In any event, it is easy to see how each of these broad categories requires the services of physicians to accomplish its stated aims. In many instances there is the need for the physician to do the actual work, while in others the physician can best serve as a coordinator of the many groups contributing to the school health program. This is not to imply that the physician should try to assume primary responsibility in areas where he is not fully competent, eg, school curriculum and teaching, but to say that he should stand ready to assist in all areas. This requires that he practice his art not only in the office, home or hospital, but also in the conference room.

In 1961 a committee on school health was activated by the Maryland Chapter of the Academy of Pediatrics and given the charge of surveying the field of school health in the State. One of the most encouraging aspects of the Committee's work to date has been the cordial reception it has received from others interested in school health. In particular, the educators have been most receptive to our inquiry and have demonstrated a sincere desire to work with us. At the start there seemed to exist a feeling among the educators that the medical profession as a group was indifferent to their problems although they readily agreed that certain individual physicians constituted notable exceptions. At the same time it was discovered that programs were being planned or carried out by educators to which physicians could have contributed. Was the lack of physician participation due to faulty communication or physician indifference? The Committee chose to believe the former.

A recent review by Rogers[2] on secondary school children in a Pittsburgh suburb identified the problems most frequently seen or discovered

by the routine physical examinations and screening procedures used in the schools. Perhaps the very low percentage of serious disabilities uncovered in this fashion gives testimony to the adequacy of the physical examinations and health care given these children prior to their entry into the school systems by their private physicians or local medical clinics. It is also encouraging to note that a survey in Maryland in 1963 revealed that in 17 of the 23 counties over 80% of the children entering school for the first time were accompanied by a certificate of physical examination made prior to their entry into the school system. Six counties and the City of Baltimore reported a rate ranging from 20% to 75%.[3] From these findings we can infer that the physical examination of school children prior to their entry into school is being accomplished in the majority of instances, but it would seem appropriate to strive for 100% completion.

All too often, once children are in school the physician's knowledge concerning their adjustment and progress is scanty. Most of his contact with any given child continues to take the form of periodic physical examinations, which vary in frequency depending on numerous factors not necessarily related to school performance. Frequently the physician's awareness that something is wrong with a child in school comes only when he is seen because of such symptoms as abdominal pain, headache, vomiting or even refusal to go to school. In the older student, anti-social behavior is a frequent reason for seeking medical advice.

To minimize the frequency with which such problems arise, several approaches may prove helpful. First, a psychological evaluation and an appraisal of the child's emotional health should be incorporated in the pre-school physical examination. From a more detailed investigation in these areas, many times one can predict or question the response of the first-grader to the school setting and give valuable information to the teachers that may assist them in making the child's transition from home to school a smoother one. Pollack,[4] in a recent article in the *Bulletin* from the Children's Hospital in Washington, DC, outlined some procedures for evaluating children in this fashion. All of these tests will find ready application in the physician's office.

Second, it is important to take the initiative and to ask specific questions concerning the child's progress in school at each opportunity. Recent figures[5] indicate that the vast majority of school-age children are seen by their physicians on an average of three or four times a year for various reasons. At these times appropriate questions can be put to both the child and the parents.

Third, there should be no reluctance on the part of the physician to contact the school to discuss the child's progress and to seek data and information from this source that will be helpful in treating and counseling the patient. In many instances, once the physician has evaluated the situation to his satisfaction and has recommendations to make, it may be useful to impart this information at a meeting arranged with the teachers, the school physician and the school health nurse. These conferences present an unsurpassed means of conveying the medical viewpoint to the situation.

For physicians who have a deeper interest in school health, opportunities are present to serve in other ways: (1) In many areas opportunities to serve as a school health physician are available. For the most part, the school health physician will function in an advisory capacity and act as a liaison between educators and private medical practice in the interest of the student. At the same time he is given excellent opportunities to instill medical thought and guidance in the educational process. (2) Physicians can and should serve on local school health councils. Here they will encounter the diversity of interests and opinions voiced by many special interest groups, all of which are aimed at the improvement of the health of school children, and they will be presented with an opportunity to maintain a proper balance between and among these groups and their contributions to school health. In this same context, physician participation is mandatory in planning local implementation of governmental programs which involve the area of school health directly or indirectly if the programs are to be of maximum benefit to the school child and the nation. Intelligent use of medical manpower and the existing medical data for each child is requisite to the success of these programs. Service on a school health council would probably appeal most to the civic-minded physician for it brings him into direct contact with many civic groups. (3) Finally, there continues to be an extreme need for the application of scientific investigation to the process of learning. The accumulation of accurate



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data is wanting. Certainly there is a tremendous need for physician participation in this area. It is the role best assumed by the medical researcher and those in allied disciplines. The medical school setting offers the best base for operations of this nature.

In summary, the problems of school health are being met adequately in many areas, but deficiencies and gaps do remain. Of paramount importance in enhancing school health programs is the greater participation of the physician. The physician, in almost all instances, will find his genuine interested appreciated, but it remains for him to take the initiative. The plea is made here for physicians to assume this responsibility to an increasing degree.

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Acid stable, better absorbed ... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food[1-3]

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

700121

Ilosone®

Lilly

Erythromycin Estolate

(See next page for prescribing information.)

Ilosone®/ the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with pre-existing liver disease or dysfunction.

Side-Effects: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have appeared in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly if the drug is readministered to sensitive patients, usually within forty-eight hours. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appeared to be definitely related to use of the drug, laboratory findings w characterized by increased direct-reacting bilirubin, eleva alkaline phosphatase levels, negative or weakly positive cepha flocculation and thymol turbidity tests, elevated serum glutar oxalacetic transaminase levels, peripheral eosinophilia, and n mal cholecystograms.

Individual idiosyncrasy seems evident since jaundice has been reported in other patients taking prolonged courses of medication. Patients with chronic infection have been given 1 to 2 Gm. of the drug daily for periods of two to six months, a patients with rheumatic fever have taken prophylactic doses 0.5 Gm. daily for two years without difficulty. In one group 144 patients who received the drug daily for two years, no ja dice was noted. It was of interest that members of six of th patients' families, who were not taking the drug, had episo of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels w determined in a group of fifty-four adults and children who t 250 mg. of Ilosone daily for an average of sixteen months rheumatic fever prophylaxis. The results were compared w those of a similar group of forty-four patients who received pe icillin. There were no cases of jaundice in either group. Elevati of SGPT and serum alkaline phosphatase levels during the cou of treatment was observed in one patient treated with Ilos and in two patients treated with penicillin. Seven other patie in the group receiving Ilosone and four others in the penicil group showed elevations in one of the tests at some time duri administration of the drugs.

Very satisfactory therapeutic results, without toxicity, we reported in 102 pediatric patients who received short-term (te day) courses of Ilosone in the treatment of streptococcus inf tions. Results of liver function tests in these patients were co parable to those in a similar control group who had receiv penicillin.

Gastro-intestinal disturbances not associated with hepatic e fects are observed in a small proportion of individuals as a res of a local stimulating effect of the medication on the alimenta tract; however, the normal intestinal gram-negative bacteri flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with the u of erythromycin, there have been occasional reports of urticari skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orally.

Ilosone Pulvules®
Ilosone Chewable Tablets
Ilosone Drops
Ilosone, 125, for Oral Suspension

For infants and for children under twenty-five pounds of bod weight, the usual dosage is 5 mg. per pound every six hours; f children twenty-five to fifty pounds, 125 mg. every six hour (Tablets Ilosone Chewable should be chewed or crushed an swallowed with water.)

For adults and for children over fifty pounds, the usual dosag of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythromyc therapy should be considered.

In the treatment of syphilis, the recommended total dosage 20 to 30 Gm. given in divided doses for a period of ten to fiftee days. Close follow-up of the patient is necessary since erythr mycin drugs have not had adequate evaluation in all stages syphilis. Examinations of spinal fluid are recommended as pa of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four days a recommended. In the treatment of gonorrhea, patients with suspected lesion of syphilis should have a dark-field examinatio before receiving antibiotics, and monthly serologic tests shou be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and 250 mg (equivalent to base), in bottles of 24 and 100.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to base) in bottles of 50.

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 10-cc. size packages, with dropper calibrated at 25 and 50 mg.

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equivalen to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size package

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:69, 196
2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:398, 196
3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 196

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.

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REHABILITATION Notes

REHABILITATION SECTION
BALTIMORE CITY MEDICAL SOCIETY,

DOUGLAS G. CARROLL M.D.
EDITOR

An Upper Extremity Function Test

DOUGLAS CARROLL, MD
Chief, Physical Medicine and Rehabilitation
Baltimore City Hospitals

For a number of years, we have been using a test for upper extremity function designed to give an estimate of how useful an upper extremity is in the performance of daily activities. The original test[1] has undergone some minor changes and the form now in use in shown on page 98.

The test is based on the theory that there are certain basic functions carried out by an upper extremity, at least one of which is necessary to perform most daily activities. These basic functions are called grasp, grip, lateral prehension, pinch, placing, supination and pronation of the arm, flexion-extension of the arm, and flexion, extension and abduction of the shoulder. In addition to these basic functions, a measure of grip strength on a Smedley Dynamometer, and the pinch strength between the thumb and digits two to five, are recorded.

Pinch between thumb and digits two to five makes up a large part of the test. This activity is unique to man and is one of the reasons that his hand is so much more useful in fine movements than the hands of lower evolutionary forms.

Figures 1 through 6 illustrate the performance of the test by a patient with severe rheumatoid arthritis of the upper extremities.

The test had been used in a large number of different pathological conditions. It is particularly helpful in comparing and following hand performances in an individual patient. By comparing the results of tests performed at different time intervals in the same patient, it is possible to observe accurately how upper extremity function is changing.

We have found that performance varies from week to week in the patient with active rheumatoid arthritis. In such a patient, pain in any of the joints of the upper extremity limits function far more than static loss of range of motion, ankylosis, dislocation of joints, or ulnar deviation of the fingers.

In the hemiplegic patient, there is a fairly common pattern of return of function. In a general way, return of upper extremity motor function after hemiplegia follows the evolutionary development of hand function. That is, movement returns first in the shoulder and elbow, and is followed by return of function in the hand, with pinch between the opposable thumb and digits two to five (unique to man) coming last. If several weeks after a patient suffers an acute hemiplegia, there is no function whatsoever in the upper extremity (defined as 0 score on the test),

UPPER EXTREMITY FUNCTION TEST

History # _____

Name: _____ Date _____

Basic Function		Maximal Score	R.	L.	R.	L.	R.	L.
GRASP	1. Block 4″	3						
	2. Block 3″	3						
	3. Block 2″	3						
	4. Block 1″	3						
GRIP	5. Pipe 1¾″	3						
	6. Pipe ¾″	3						
LATERAL PREHENSION	7. Slate 1″ x ⅝″ x 4″	3						
	8. Turn key right	3						
	9. Turn key left	3						
PINCH Marble ⅝″	10. Ball 3″	3						
	11. Index Finger	3						
	12. Middle Finger	3						
	13. Ring Finger	3						
	14. Small Finger	3						
Ball Bearing ⅛″	15. Index Finger	3						
	16. Middle Finger	3						
	17. Ring Finger	3						
	18. Small Finger	3						
Ball Bearing ¼″	19. Index Finger	3						
	20. Middle Finger	3						
	21. Ring Finger	3						
	22. Small Finger	3						
Ball Bearing ⅜″	23. Index Finger	3						
	24. Middle Finger	3						
	25. Ring Finger	3						
	26. Small Finger	3						
PLACING	27. Washer over nail	3						
	28. Iron to shelf	3						
SUPINATION and PRONATION	29. Pour water from pitcher to glass	3						
	30. Pour water from glass to glass (Pron)	3						
	31. Pour water back to first glass (Supin)	3						
	32. Write name (dominant hand only)	(3)						
ARM PLACING (Score 1 if completed)								
	33. Place hand on head in midline	1						
	34. Place hand behind head in midline	1						
	35. Place hand behind back to midline	1						
	36. Place hand to mouth	1						
	TOTAL	100						
SMEDLEY DYNAMOMETER READING:								
PINCH STRENGTH READING: (Ball of thumb to ball of finger unless otherwise specified)								
	Thumb and index							
	Thumb and middle							
	Thumb and ring							
	Thumb and small							
	Pain interferes with function							

SCORING ITEMS 1 TO 32

3—Performs test normally.
2—Completes test, but uses abnormal movements, takes abnormally long time or has great difficulty. (Abnormal movements include using grasp instead of grip in items 5 & 6, pinch in items 7, 8 or 9, lateral prehension in items 11 to 25).
1—Performs test partially.
0—Can perform no part of test.

Describe unusual findings on back of form.

TEST PERFORMANCES BY PATIENT WITH SEVERE RHEUMATOID ARTHRITIS OF THE UPPER EXTREMITIES



Fig 1
Item 2: Grasp of 3″ Block



Fig 3
Item 9: Lateral Prehension
(Patient has arthrodesis of the first M-P joint.)



Fig 2
Item 5: Grip of 1¾″ Pipe
(Patient shows inability to flex the fingers, particularly d4 and d5, around a pipe.)



Fig 4
Item 10: Pinch of 3″ Ball
(Patient shows inability to place it on a shelf because of poor extension of the elbow.)

(Figures 5 and 6 are on the following page)

then it is unlikely that the patient will regain significant function in that extremity.

A number of other diseases, including burns and trauma to the hands, are being studied. A few patients are being studied pre- and post-operatively to evaluate the significance of changes in hand function. To date, the test has helped clarify and make more precise the nature of functional changes caused by disease, trauma and surgery.

REFERENCE

Carroll, D. G.: A Quantitative Test of Upper Extremity Function, *J Chronic Dis* **18**:479, 1965.

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TEST PERFORMANCES BY PATIENT WITH SEVERE RHEUMATOID ARTHRITIS OF THE UPPER EXTREMITIES

(continued)



Fig 5
Item 11: Pinch of 5/8" Marble between thumb and d2
(Patient's performance here, and with d5, was normal, but pinch between the thumb and d3 or d4 was impossible because of extension contractures at the PIP joints of these two digits.)



Fig 6
Measurement of Strength of Pinch between thumb and d3 of left hand

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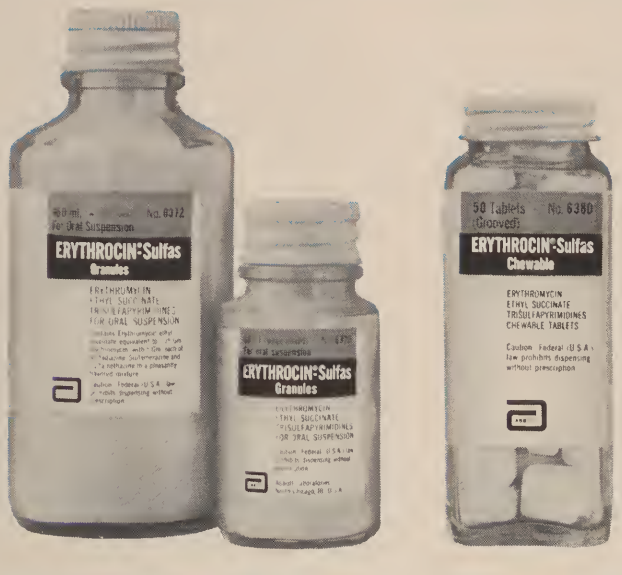
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FACTS, NOT FADS



Perhaps there have been times when you wanted to prescribe erythromycin and triple sulfas for little patients. Now you can—with a choice of two new fine-tasting pediatric forms.

New–Two Pediatric Forms of Erythromycin and Triple Sulfas



ERYTHROCIN®-SULFAS Chewable (Erythromycin ethyl succinate-trisulfapyrimidines chewable tablet)

In clinical trials[1,2], this orange-flavored tablet was given to 55 patients, aged four months to 18 years.

Diagnoses (multiple in some cases) represented a cross section of bacterial infections commonly seen in pediatric office practice.

Therapy was given from three to 12 days, with an average of six days.

Of the 55 patients, 30 were reported cured within 72 hours, while 22 showed partial recovery within the same time, and subsequent clinical cure.

A clinical cure rate of 94.5%

ERYTHROCIN®-SULFAS Granules (Erythromycin ethyl succinate-trisulfapyrimidines granules for oral suspension)

87 patients were treated[1,2]—all children, ages four months to 15 years.

The diagnoses were multiple in some cases and were chiefly bacterial infections of the respiratory tract.

Dosage was maintained from three to 10 days; average treatment was five days. All of the ill children accepted the orange-flavored suspension favorably.

53 were clinically cured within 72 hours, while 32 showed partial relief within the same time, and subsequent clinical cure.

701358

A clinical cure rate of 97.7%

1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

ABBOTT

Brief Summary on next page

ERYTHROCIN®-SULFAS
Brief Summary

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or newborn infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. of each of sulfadiazine, sulfamerazine and sulfamethazine.

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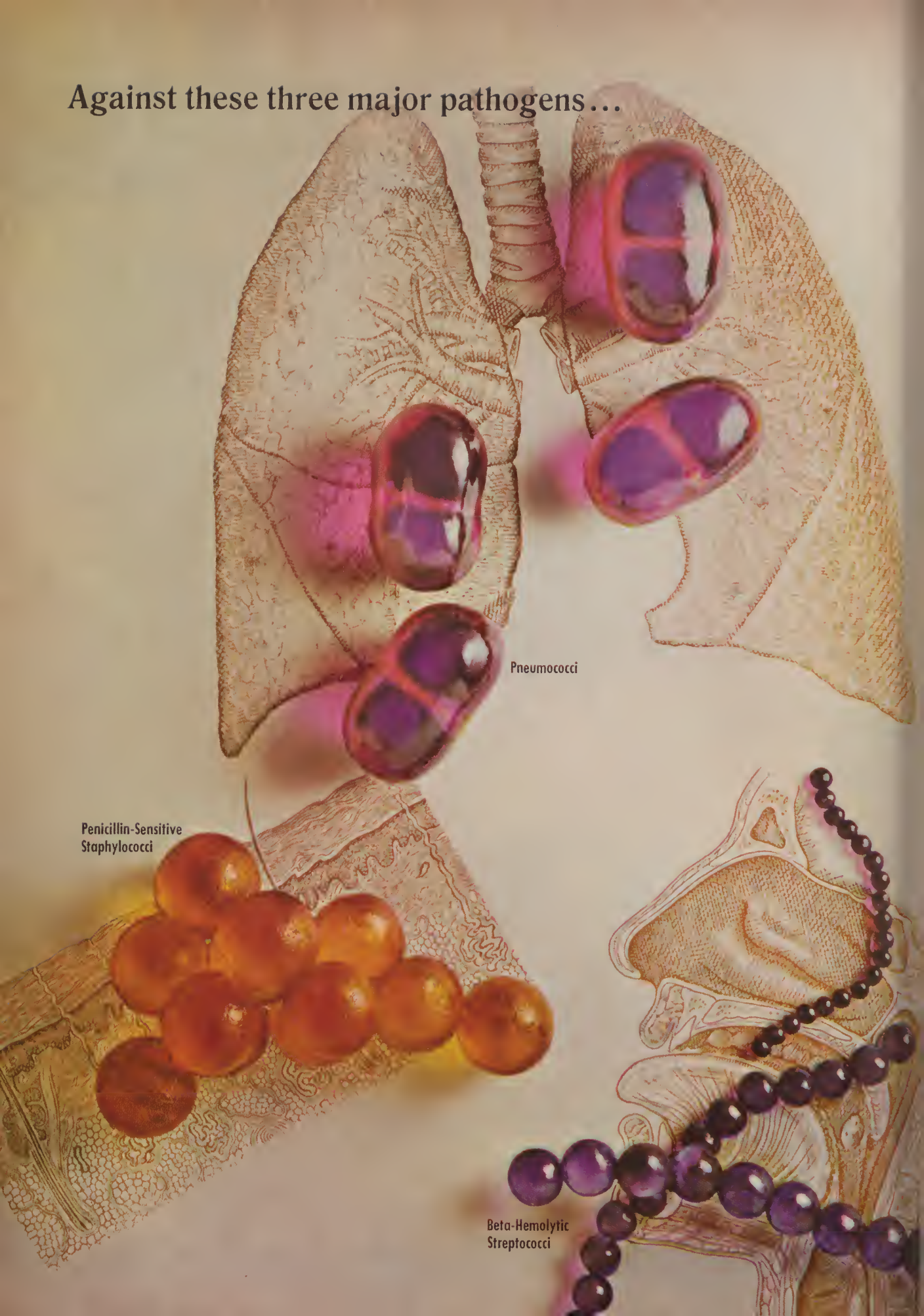
prescribe economical Trisulfaminic®

Each tablet contains: Triaminic® 25 mg. (phenylpropanolamine hydrochloride 12.5 mg., pheniramine maleate 6.25 mg., pyrilamine maleate 6.25 mg.); Trisulfapyrimidines, U.S.P. 0.5 Gm. (sulfadiazine 0.167 Gm., sulfamerazine 0.167 Gm., sulfamethazine 0.167 Gm.)

PHARMACOLOGY: Triaminic decongests and promotes drainage of nasal and paranasal passages, and prevents any further histamine-induced damage; the triple sulfonamides inhibit susceptible bacterial invaders. INDICATIONS: For congestion and infection of the upper respiratory tract caused by sulfa-susceptible organisms. DOSAGE: Adults: 2 to 4 tablets initially, followed by 2 tablets every 6 hours. Medication should be continued until patient has been afebrile for 3 days. ADVANTAGES: The advantages of Trisulfaminic in upper respiratory infections are: freedom from narcotics or alcohol; therapeutic reliability; safety; economy; ease of administration; freedom from potential sensitization to broad-spectrum antibiotics which may be reserved for lower respiratory or other infections caused by susceptible organisms. CONTRAINDICATIONS: Contraindicated in sulfonamide and antihistamine sensitivity, impaired renal function, pregnancy approaching term, and in premature infants and newborn infants during the first month of life. Do not use in patients with glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction. WARNING: Use only after careful evaluation in patients with liver or renal damage, urinary obstruction, or blood dyscrasias. Deaths have been reported from hypersensitivity reactions with administration of sulfonamides. In intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed periodically. Sulfonamide therapy may potentiate the hypoglycemic action of sulfonylureas. PRECAUTIONS: Use with caution in patients with histories of significant allergy or asthma. Assure an adequate fluid intake. Because the antihistamines may cause drowsiness of varying degree, warn patients about activities requiring alertness such as driving a car or operating dangerous machinery. Use with caution in the presence of hypertension, hyperthyroidism, cardiovascular disease and diabetes. ADVERSE REACTIONS: As in all sulfonamide therapy, the following reactions may occur: headache, nausea, vomiting, diarrhea, icterus, hepatitis, pancreatitis, urticaria, rash, fever, cyanosis, hematuria, crystalluria, proteinuria, blood dyscrasias, petechiae, purpura, neuropathy and injection of the conjunctiva and sclera. If one or more of these reactions occur, the drug should be discontinued. With antihistaminic therapy there have been reports of sedation varying from mild drowsiness to deep sleep, dizziness, lassitude, inability to concentrate, fatigue, incoordination, tinnitus, blurred vision, diplopia, euphoria, nervousness, insomnia, tremors, palpitation, hypotension, headache, chest tightness, urinary frequency, dysuria, tingling of the hands, dryness of the mouth, throat, and nose, gastrointestinal disturbances such as epigastric distress, anorexia, nausea, vomiting, constipation and diarrhea and very rarely, leukopenia and agranulocytosis. Adverse reactions reported with the use of sympathomimetic amines include anxiety, tension, restlessness, nervousness, tremor, weakness, insomnia, headache, palpitation, tachycardia, angina, elevation of blood pressure, sweating, mydriasis, anorexia, nausea, vomiting, dizziness, constipation, and dysuria due to vesicle sphincter spasm. PACKAGE INFORMATION: Trisulfaminic Tablets: Supplied in bottles of 100 tablets. CAUTION: Federal law prohibits dispensing without prescription.

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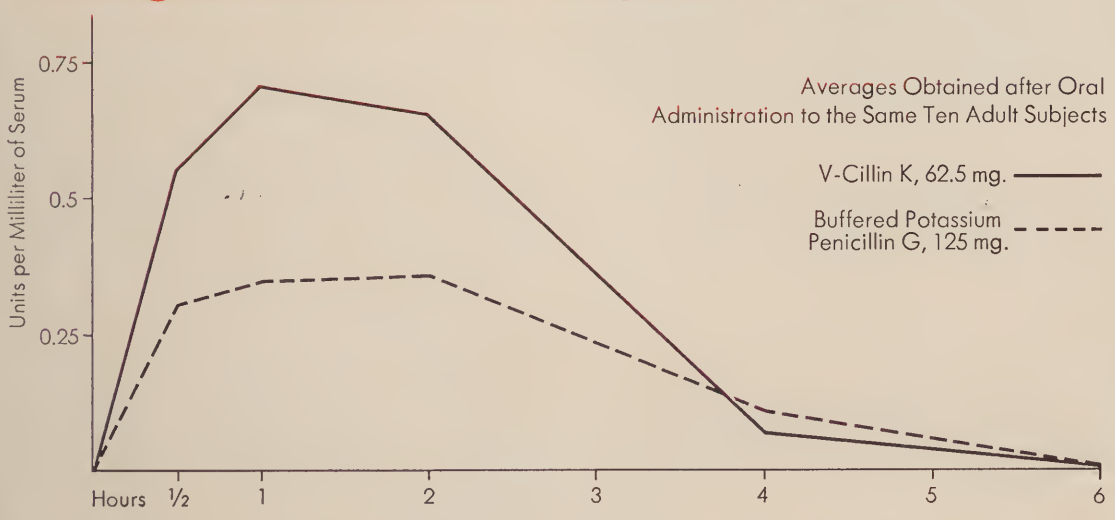
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Penicillin V	0.02	0.02-0.04	0.02	0.003-0.4	0.01	0.005-0.2
Penicillin G	0.02	0.005-1.6	0.005	0.002-0.2	0.02	0.01-0.1
Methicillin	1.6	0.4-6.3	0.2	0.1-0.4	0.2	0.1-1.6
Oxacillin	0.4	0.1-3.1	0.04	0.02-0.4	0.1	0.04-0.8
Cloxacillin	0.2	0.2-0.8	0.1	0.1-0.8	—	—
Nafcillin	0.4	0.2-0.8	0.04	0.02-0.1	0.02	0.02-0.2
Ampicillin	0.2	0.1-0.8	0.02	0.01-0.04	0.02	0.01-0.04

Adopted from Klein, J. O., and Finland, M.: New England J. Med., 269:1019, 1963.

with high blood levels, even in the presence of food



Adopted from Griffith, R. S., and Block, H. R.: Current Ther. Res., 6:253, 1964.

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Potassium Phenoxymethyl Penicillin

(See next page for prescribing information.)

New 500 mg. tablets...a more convenient way to give high doses



Description: V-Cillin K is the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly). This chemically improved form combines acid stability with immediate solubility and rapid absorption. Higher serum levels are obtained more rapidly with this penicillin than with equal oral doses of penicillin G. The higher serum levels and acid stability of V-Cillin K make it a more dependable penicillin for oral use.

V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

Indications: V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy. Reactions occur more frequently in individuals with bronchial asthma or other allergies or in those who have previously demonstrated sensitivity to penicillin. If hypersensitivity reactions occur, the drug should be discontinued.

Adverse Reactions: Although serious allergic reactions are much less common with administration of oral penicillin than with intramuscular forms, skin rash, symptoms resembling those of serum sickness, or other manifestations of penicillin allergy may occur. When penicillin is administered, measures for treating anaphylaxis should be readily available. Those include epinephrine, oxygen, and pressor drugs for relief of immediate allergic manifestations as well as antihistamines and corticosteroids for delayed effects.

The use of antimicrobial agents may be associated with the overgrowth of antibiotic-resistant organisms; in such a case, antibiotic administration should be stopped and appropriate measures taken.

Administration and Dosage: For Tablets V-Cillin K and for V-Cillin K, Pediatric, the usual dosage ranges from 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, the daily dosage may be 50 mg. per Kg. of body weight divided into three doses.

Beta-hemolytic streptococcus infections without associated bacteremia may be treated with 200,000 to 400,000 units three times a day. Therapy should be continued for a minimum of ten days to prevent development of rheumatic fever and/or other serious complications. Dosage for routine streptococcus prophylaxis in patients with a history of rheumatic fever or congenital heart disease may be 200,000 units once or twice daily. When such patients undergo tonsillectomy, tooth extraction, or other minor surgery, the prophylactic dose should be 500,000 units every six hours given two days prior to surgery and for two days postoperatively. If oral medication is not feasible on the day of surgery, parenteral therapy should be considered. Mild to moderately severe pneumococcus pneumonia has been treated effectively with 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be given every six to eight hours in conjunction with indicated surgical procedures.

For gonorrhea in males, 500 mg. (800,000 units) every six hours for three doses may be employed; in females, 500 mg. every four hours for six doses are recommended. Patients with a suspected lesion of syphilis should have a dark-field examination before receiving penicillin and monthly serologic tests for a minimum of three months.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units) in bottles of 50 and 100; 250 mg. (400,000 units), and 500 mg. (800,000 units) in bottles of 24 and 100.

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 units) per 5 cc. of solution, in 40, 80, and 150-cc.-size packages.

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

Lilly

the HEART PAGE

A Service of The Heart Association of Maryland

Elijah Saunders, MD—*Editor*

Coronary Care Units: Part I

LEONARD SCHERLIS, MD
Head, Division of Cardiology

JERRY SALAN, MD
Director, Coronary Care Unit

University of Maryland Hospital and School of Medicine

Atherosclerosis and its complications are the leading causes of death today despite the many advances which have been made in the last 20 years. In the United States, more than one-half million deaths occur each year from myocardial infarction with over 150,000 occurring in persons less than 65 years of age. More than one-half million patients are admitted annually to hospitals with a diagnosis of myocardial infarction. The hospital mortality for acute myocardial infarction is approximately 30 deaths per 100 admissions and 70% of all of these deaths occur in the first five days after admission. Many of these fatalities are due to cardiac arrhythmias and cardiac arrests.

At the present time, a positive program is available which promises to have an immediate effect on reducing the mortality rate from myocardial infarctions: the coronary care unit. Much of the impetus for the development of coronary care units evolved from the encouraging results of cardiopulmonary resuscitation in instances of cardiac arrest. In 1964, Jude, Kouwenhoven, and Knickerbocker reported a survival rate of 25% in a collected series of 1,270 patients. In one series, 69% of the arrests occurring in the operating room were resuscitated to pre-arrest status as compared with 20% of those in the general hospital area. Success in cardiac resuscitation measures is dependent not alone on the etiology of the arrest, but on the promptness and efficacy with which resuscitation efforts are applied. The first coronary care unit in the United States was established in the spring of 1962 at the Bethany Hospital in Kansas City and the second several months later in Philadelphia. There were less than 50 coronary care units in 1965, 100 in March, 1966, and there are more than 200 at the present time.

This rapid acceptance of the concept of coronary care units is based upon evidence that the availability of the necessary medical staff, nursing personnel, monitoring equipment, and therapeutic measures can significantly reduce the anticipated mortality in the initial course of an acute myocardial infarction Assuming that cost was not a factor, the "best" therapy available ten years ago for the patient with a myocardial infarction was a private room, private nurses around the clock, the "frequent" recording of vital signs, ie, every one to three hours, and specific medication as dependent upon the personal experience of the attending physician. The occurrence of such sudden events as cardiac failure or arrhythmias was

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too often characterized by significant delays in recognition and therapy until the episode had become clinically severe and obvious. Cardiac arrest signaled the termination of therapy and the death of the patient. By way of contrast, the concept of a coronary care unit is to gather together in one area the personnel and materials necessary to recognize and treat early changes in the status of the patient with a myocardial infarction before they become emergencies.

The coronary care unit must be evolved carefully, with all of the professional, administrative and service personnel brought into the early stages of planning. Careful attention to all details of construction and administration is necessary because of the needs which will arise for adequate conduits, electrical outlets, oxygen, suction, lighting, console, nurse and physician desks, utility room, and emergency resuscitation and communication equipment.

The selection of monitoring equipment poses problems only because of the availability of satisfactory products from many suppliers. Estimates for equipment range from $1,000 to $5,000 per bed, depending on the complexity of the equipment desired. There are several guidelines which are of value in making a final choice:

1. The monitoring equipment should be kept comparatively simple for routine operation.

2. The most reliable parameter to follow is the electrocardiogram and it should be followed constantly.

3. A wall-mounted oscilloscope at the bedside is a basic requirement for the patient and the oscilloscope should be readily visible from as much of the unit as possible.

4. The central nursing station should have a "slave" oscilloscope and electrocardiograph recording equipment so that an electrocardiogram can be selectively triggered by an alarm and the patient's position indicated on the tracing.

5. A visible and audible alarm system for each patient is required. A "pulse rate beeper" is usually not advisable.

6. Rate-meters with high-low alarms at the bedside and at the nurse's stations are desirable.

7. Pacemakers and defibrillators should be immediately available.

8. There should be equipment for determining central venous pressures.

9. The monitoring of respiration, temperature, and intra-arterial blood pressure is technically feasible and under certain circumstances desirable.

10. The use of memory tapes is not necessary on a routine basis, but is of value for investigation and teaching purposes.

11. Prime consideration in the selection of any equipment is the manufacturer's service and reliability, the frequency of repair, and the safety of the equipment.

The equipment should be so selected, positioned, and utilized that it does not constitute a physical or conceptual barrier to the chief function of the coronary care unit, ie, careful observation of the patient and the prompt institution of emergency therapy. Equipment is used as an adjunct and is not to replace direct observation.

Alcoholism SECTION

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

A Challenge to the Medical Profession

ISADORE TUERK, MD
Commissioner, Department of Mental Hygiene, State of Maryland

Early this year the United States Court of Appeals for the Fourth Circuit (which includes Maryland and four other states) held, in the case of Driver v Hinnant, that to convict a chronic alcoholic of public drunkenness violates the prohibition against cruel and unusual punishment contained in the Eighth Amendment to the United States Constitution. The defendant, Joe Driver, was represented by attorney-at-law Peter Barton Hutt, whose efforts on behalf of alcoholics are remarkably similar to those of Dorothea Lynd Dix a hundred years ago on behalf of the mentally ill.

The decision carries a strong recommendation to Maryland judges to transfer to treatment and rehabilitation agencies their centuries-old responsibility for alcoholics who have been arrested for, quite simply, displaying a symptom of their disease.

What are the implications of the historic decision for physicians, general hospitals, and other public and private agencies concerned with services to alcoholics and programs of alcoholism control?

In the first place, the decision demands that we demonstrate with much more vigorous action our conviction that alcoholism is a disease, and the alcoholic a sick person who can and should be treated. The action we have taken in the past has resulted in treatment in psychiatric hospitals and clinics of approximately 3,000 alcoholics—probably three per cent of the State's total alcoholic population. But a recent survey indicates that in the 18 months between January 1, 1964 and July 1, 1965, more than 3,500 individuals had from two to 18 convictions a year as drunkenness offenders in Maryland courts. If, as we are advised, 90% to 95% of this group have serious drinking problems, then the statistics suggest that we must more than double our present specialized facilities in order to provide appropriate treatment for those alcoholics now revolving helplessly through Skid Row, police lock-ups, courts and jails.

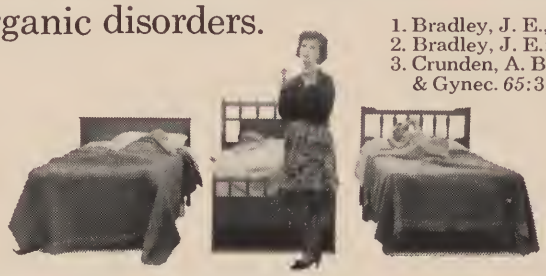
In the second place, the alcoholics in this long-neglected population are almost all homeless men, socially as well as economically bankrupt. To treat them as sick people, we must not only expand our present services, but add new ones: medically supervised detoxification units, for example; a network of residential facilities geared, to quote Mr. Hutt, "to reverse the process of degradation that has gradually forced the derelicts down to their present position;" and, of course, the long-term rehabilitation facility to which this State is already committed.



Togetherness....

...can be rough when epidemics of nausea and vomiting strike a family. Emetrol offers prompt, safe relief. It is free from toxicity[1] or side effects[2,3] and will not mask symptoms of serious organic disorders.

1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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Finally, the decision is a warning that we must take *immediate* action to provide for the population under discussion if we are to avoid tragic suffering and death in the back streets and alleys of our State. Again to quote Mr. Hutt:

"Cases are now proceeding through the courts in various states which may be presented to the Supreme Court within the year. Thus, it can . . . be anticipated that within a short period of time the United States Supreme Court will hand down a ringing decision adopting the result of the . . . Driver decision as a nation-wide rule of law. Public officials should be urged . . . to act now to set up reasonable public health programs for the treatment of alcoholics before the courts require them to do so."

RESEARCH IN PLASTIC SURGERY

The secret of successful survival of skin and organ transplants in man may lie in massive dosing of the recipient with material derived from certain strains of heat-killed streptococci and staphylococci.

Since 1964, researchers at the New York University Medical Center have been identifying and testing bacterial micro-organisms which are highly effective in sensitizing mammals to tissue transplants. Since these micro-organisms are widespread in nature, they offer a limitless supply of transplantation antigens and a possible answer to safe suppression of the body's natural rejection response to foreign tissue.

This information was disclosed in a report made by a research team at the New York University Medical Center to The John A. Hartford Foundation, Inc., which provided a grant of $132,487 to the Center's Institute of Reconstructive Plastic Surgery in 1964.

From New York University News Bureau, Jan, 1967.

DEPARTMENT OF HEALTH
STATE OF MARYLAND
William J. Peeples, MD, MPH, *Commissioner*

HIGHLIGHTS

New Test for Rubella Immunity

As of January 3, a new, highly sensitive, rapid, and reliable test for rubella antibody was made part of the routine examination of all pregnancy blood specimens at the Bureau of Laboratories.

Maryland is the first state to offer the "HI" (Hemagglutination Inhibition) test, which was developed by scientists in the Division of Biologics Standards at the National Institutes of Health.

The new procedure requires only a few hours, is extremely accurate, and can demonstrate immunity acquired many years previously. When rubella is suspected, a second test made after a ten-day interval will show whether the antibody represents old immunity or a new disease process.

Commissioner Elected to AAPHP

State Health Commissioner William J. Peeples, MD, was chosen President-Elect of the American Association of Public Health Physicians at the annual meeting in California. He will assume the presidency next year.

Grant to Governor's Commission on Tuberculosis

The Governor's Commission to study tuberculosis in Maryland, created in 1965, has received a $10,950 grant from the Department and the Maryland Tuberculosis Association to assist in completion of the work. The study was requested by these agencies and by the Medical and Chirurgical Faculty of the State of Maryland.

Clinical Laboratory Tests in Maryland

In Maryland's 118 registered laboratories, excluding those operated by the State or by the federal government, 10,200,000 tests were performed in 1965—9.1 million in hospital laboratories and 1.1 million in private or "independent" clinical laboratories.

Not subject to the new regulations governing licensed laboratories are the office laboratories of practicing physicians, where an estimated 7 million tests are performed each year. The Bureau of Laboratories is attempting to raise the level of dependability of these office procedures by (1) recommending that the US Public Health Service provide guidance by evaluating the relative merits of the various commercially available kits and "sticks," and (2) developing training courses for office technicians, to be given at the request of a physician.

Maryland's Hill-Burton Plan Approved

The 1967 State of Maryland plan for use of Hill-Burton funds in the construction and modernization of hospital and medical facilities has been approved by the US Department of Health, Education, and Welfare. This makes available, in matching funds for this fiscal year, $3,519,935, which is allocated to projects already approved by the Advisory Council on Hospital Construction.

Premature Infant Training Program

In cooperation with the Johns Hopkins Hospi-

DIARRHEA



CANTIL®
(mepenzolate bromide)

LAKESIDE

Diarrhea, one of the most vexing symptoms of common G. I. disorders can often be curbed with Cantil (mepenzolate bromide), bringing welcome relief to the harassed patient. Relatively specific for the hyperactive colon, it helps reduce diarrhea, pain and spasm with minimal effect on other viscera. Cantil (mepenzolate bromide) is indicated whenever these symptoms are associated with irritable colon, gastroenteritis, diverticulitis, and mild to moderate ulcerative colitis.

It is an anticholinergic drug without narcotic properties. Side effects are usually mild.

IN BRIEF: One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth, blurring of vision, constipation, nausea, vomiting, bloating and dizziness may occur but are usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy — withhold in glaucoma. Contraindicated in patients sensitive to phenobarbital and/or Cantil (mepenzolate bromide); in toxic megacolon, obstruction of G. I. or G. U. tract.

SUPPLIED: CANTIL (mepenzolate bromide) — 25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL — containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

tal, the Division of Maternal and Child Health is offering to graduate professional nurses a work-study program in the care of low-birth-weight infants in hospital nurseries. Four sessions have been scheduled for the two-month, tuition-free course, which is given at the Children's Medical and Surgical Center of the hospital.

Revised Maryland Nursing Manual Published

The Department's "Manual of Nursing and Special Procedures," recently revised, is especially useful for development of comprehensive programs for care of the sick in the home, and should be particularly helpful in implementing the "home health services" provided for in the federal government's program of health insurance for the aged. The manual is in demand by agencies in other states as a standards guide.

Medicare's Extended Care Facilities Confusion

A concentrated effort has been made to correct what seemed a general misapprehension regarding extended care facilities—namely, that up to 100 days of ordinary nursing home care would be covered, wholly or in part, for Medicare beneficiaries, beginning January 1, 1967.

The following information may prove helpful to physicians in explaining the conditions of the coverage to their medicare patients: An extended care facility is a special kind of nursing home offering 24-hour skilled nursing care, and meeting certain other requirements. It is primarily a convalescent center, designed for the recently hospitalized patient who is not ready to return home, but still requires a high level of nursing or rehabilitative care for a limited period.

An extended care facility will most often be a wing or unit of a hospital or nursing home, rather than a completely independent institution. Other facilities are classifed by the new state regulations as "long-term care" and "personal care" homes. Although these, too, must be licensed by the State, they are not eligible for Medicare payments.

There are, as well, certain conditions which apply to the patient:

1. He must, under order of a physician, have spent at least three days in a general hospital for treatment of an acute illness.
2. He must, of course, have become eligible for Medicare before his discharge from the hospital, and his discharge must have taken place on or after July 1, 1966.
3. He must enter or have entered an extended care facility within 14 days after his discharge.
4. He must require continued, skilled nursing care for the condition for which he was hospitalized.

If the physician decides, before the 100 days have passed, that he no longer needs the services of an extended care facility, his Medicare benefits cease. Whether he remains in the facility or transfers to another type of nursing home, he will have to pay further bills himself.

Of course, needy or medically needy persons eligible for Medical Assistance may continue to receive nursing home care under this State program. Administered by the Health Department, the Medical Assistance program does not cover personal or custodial care, but needy persons may qualify for such benefits through the Welfare Department.

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ANEMIA



Imferon®
(iron dextran injection)

There's as much iron . . . 250 mg. . . . in a 5 cc. ampul of Imferon (iron dextran injection) as in a pint of whole blood. When iron deficient patients are intolerant of oral iron . . . or orally administered iron proves ineffective or impractical . . . or if the patient cannot be relied upon to take oral iron as prescribed, Imferon (iron dextran injection) dependably increases hemoglobin and rapidly replenishes iron reserves. Precise dosage is easily calculated.

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IN BRIEF: ACTION AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion as a source of iron; infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

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BALTIMORE CITY HEALTH DEPARTMENT

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Learn To Do Your Part In The Prevention Of Disease

Baltimore's Health in 1966

The following events are described as the most significant health developments of 1966.

1. Rapidly changing child-bearing patterns that result in a decline in total births and, as a consequence, smaller size families.
2. Highly successful control of all child diseases for which a specific inoculant exists, including diphtheria, whooping cough, tetanus, and poliomyelitis. (Measles, a childhood disease now subject to near eradication by vaccination, occurred with a high frequency during the early part of the year, before the new vaccine could be widely used.)
3. No essential reduction in active tuberculosis, nor in the venereal diseases.
4. An exceptionally severe attack upon the population by infectious hepatitis.
5. An exceptional loss of life due to homicide.
6. A record high loss of life due to accidents.
7. No significant change in the major disabling conditions, heart disease, cancer, stroke and acute respiratory disease.

The principal administrative accomplishments cited are:

1. Establishment of comprehensive pediatric centers for the care of children in poor economic circumstances.
2. Commencement of a revised medical care program for indigent and medically indigent families under Title 19 of the Social Security Act, the program known nationally as Medicaid and locally as the Maryland Medical Assistance Program.
3. Improvement of the tuberculosis control program through the establishment of a Southeastern clinic and the employment of additional staff for patient care.
4. Expansion of family planning services in hospital obstetrical departments by the Planned Parenthood Association, and within the maternal hygiene clinics of the City Health Department.
5. Intensification of case-finding efforts among inner-city school-age children to discover physical factors contributing to poor intellectual performance.
6. Launching of a measles eradication effort through an extensive vaccination program among preschool children.
7. Further development of a sound and scientific program of sampling of the air to achieve control of atmosphere pollution.

Among the major disappointments was the failure to gain financial support for an urgently needed rodent elimination program.

Environmental Sanitation

The following year-end summation of important aspects of the work of the Sanitary Section has been prepared by George W. Schucker, director of Sanitary Services, Baltimore City Health Department.

Environmental Hygiene: The Division of Community Sanitation handled 3,230 complaints of

DIURESIS



MERCUHYDRIN®
(meralluride injection)

LAKESIDE

Twenty years ago the publication of "A System for the Routine Treatment of the Failing Heart"[1] established a schedule of diuretic therapy as a primary factor in the treatment of acute congestive failure. With emphasis upon daily injections of Mercuhydrin (meralluride injection) until dry weight was obtained, Gold, et al. achieved a 40% increase in improvement, in ⅓ the time, over other methods then current. Today, most medical texts continue to recommend parenteral mercurials in acute congestive failure when prompt diuresis is indicated.

Recently Modell[2] has stated: "The mercurial diuretics are the injectable diuretics of choice since they are the most potent as well as the most dependable. Their toxicity is not an important consideration either by comparison with other potent diuretics or in relation to the seriousness of the conditions in which they provide such excellent relief."

IN BRIEF

Mercuhydrin is indicated in edema of cardiac or hepatic origin and in the nephrotic syndrome; it is contraindicated in acute nephritis and in anuric or oliguric states. *The usual adult dose is one to two cc. daily or every other day until "dry weight" is obtained.* Sensitivity is rare but small initial doses are advised to minimize potential reactions; vertigo, fever, and rash have occurred. Overdosage may produce electrolyte depletion, muscle cramps, and G. I. reactions. Supplied: 1 cc. and 2 cc. ampuls in boxes of 12, 25 and 100; 10 cc. rubber capped, multiple-dose vials (intramuscular or subcutaneous use only) in boxes of 6 and 100.

1. Gold, Harry, *et al.: A System for the Routine Treatment of the Failing Heart,* The American Journal of Medicine, Vol. III, No. 6:665-692 (Dec.) 1956.

2. Modell, Walter: *Drugs of Choice 1966-1967,* p. 97, 1966.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

insanitary conditions and 2,255 inspections of day care centers, convalescent homes, foster homes, hospitals and other institutions. Eleven newly constructed swimming pools brought the total for regular inspection to 82. Inspection programs initiated in 1966 included the inspection and licensing of ambulances under City Ordinance No. 734 and the sanitary inspection of clinical laboratories conducted in cooperation with the Bureau of Laboratories of the Maryland State Department of Health.

The Division of Rodent Control serviced 3,300 complaints of rodent and insect infestation, made 16,810 inspections, and investigated 71 cases of rat bite. Training in rodent control procedures was conducted for the Interacting Neighborhood Council of the Druid area and for personnel of the Baltimore City Hospitals, the Maryland Penitentiary and the City Jail. In addition, a new training program for neighborhood, church and improvement groups was instituted to assist these groups in organizing for the sanitary improvement of their localities. Graduates of this program were appointed Volunteer Sanitation Organizers.

Food Control: Routine inspections of about 10,000 food establishments, including retail, wholesale, manufacturer's and institutional food units, disclosed improvement in sanitary conditions, with 64.8% of all establishments found to be entirely satisfactory as compared with 60.7% in 1965. Approximately 850 complaints were investigated, 975 violation notices were issued, and nearly 400,000 pounds of food were condemned as unfit for human consumption. Of the 16 incidents investigated as possible food poisoning outbreaks, only 3 were found to be caused by food. Notable among Bureau of Food Control activities in 1966 were: the closing of an unlicensed plant providing smoked salmon; participation in a plastic garbage can experiment at 20 local food establishments, which definitely proved plastic cans unsuitable as refuse containers; the investigation of suspected cases of botulism on a German freighter; and the distribution of food poisoning prevention kits to over 700 churches, social clubs and caterers.

Meat Inspection: The Bureau of Meat Inspection made 32,000 inspections of City and County slaughtering and meat processing plants. In this work the bureau staff supervised the slaughter of 175,000 animals and the processing of approximately 27,000,000 pounds of meat and meat products. Bureau veterinarians condemned 250 animals and 27,000 animal parts for having various diseases, and 4,200 pounds of meat products as unfit for human consumption. Rabies examinations of dogs were made in connection with 832 dog bite cases. The Bureau also supervised and participated in the city-wide rabies immunization program, jointly sponsored by State and local veterinary associations and the Maryland State Department of Health. Over 6,000 City dogs were vaccinated.

Milk Control: The most significant events in milk control activities in 1966 were (1) The control of pesticides as a source of contamination of the City's pasteurized milk supply, and (2) the achievement, for the 11th consecutive year, of a milk supply in which no unpasteurized milk was sold in Baltimore City.

Daily inspections were made in the City's eight milk plants to assure that all raw milk was properly pasteurized and made safe for consumption. This program of daily inspection of milk plants is a unique and essential public health measure because it is geared to prevent the sale of unpasteurized milk to the public and ensures a safe milk supply for the citizens of Baltimore at all times. Cooperation continued with the US Public Health Service and the Maryland State Department of Health in testing for radioactive fallout in milk and no unsafe levels were discovered. The milk industry continued its self-inspection activities and reported its results to the Department. Noteworthy also was the fact that 1966 was the first full year in which all milk was transported from the dairy farms to milk plants in the City in truck tanks.

Industrial Hygiene: The Metropolitan Baltimore Air Quality Survey, an official project of the Baltimore City Health Department, the Maryland State Department of Health, and the Baltimore and Anne Arundel County Health Departments, was continued during 1966 with new equipment purchases and site selections. A new portable air sampling trailer designed by the committee was exhibited at the National Conference on Air Pollution and drew favorable comment. Follow-up inspections of 120 medical X-ray units were

DEPRESSION



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ANTIDEPRESSANT FOR RAPID IMPROVEMENT

At the recommended dosage level —initially, 150 mg. per day— gratifying remission of the signs and symptoms of depression typically begins in 2-5 days. Its specificity for depression, rapidity of action and usually mild side effects are significant reasons for prescribing NORPRAMIN (desipramine hydrochloride) in depression of any type . . . any degree of severity.

A few patients, sensitive to central nervous system stimulants may become restless as depression is lifted—in such cases dosage may be reduced or a tranquilizer added.

IN BRIEF:

INDICATIONS: In depression of any kind —neurotic and psychotic depressive reactions; manic-depressive or involutional psychotic reactions.

CONTRAINDICATIONS: Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease, epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor.

RELATIVE CONTRAINDICATIONS: (1) Patients with a history of paroxysmal tachycardia. (2) Patients receiving concomitant therapy with thyroid, anticholinergics or sympathomimetics may experience potentiation of effects of these drugs. (3) Safety in pregnancy has not been established.

PRECAUTIONS: (1) Outpatient use of desipramine hydrochloride should not be substituted for hospitalization when risk of suicide or homicide is considered grave. (2) If serious adverse effects occur, reduce dosage or alter treatment. (3) In patients with manic-depressive illness a hypomanic state may be induced. (4) Discontinue drug as soon as possible prior to elective surgery.

ADVERSE EFFECTS: Side effects, usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, anxiety, agitation and stimulation, insomnia, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, tremor, allergy, agranulocytosis, altered liver function, ataxia, and extrapyramidal signs.

DOSAGE: Optimal results are obtained at a dosage of 50 mg., t.i.d. (150 mg./day). **SUPPLIED:** NORPRAMIN (desipramine hydrochloride) tablets of 25 mg.; bottles of 50, 500 and 1000; and tablets of 50 mg., in bottles of 30, 250 and 1000.

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made in cooperation with the State's Department of Health to ensure the safety of the equipment and the prevention of unnecessary exposure to radiation of patients and medical personnel. The Department continued its measurement of radiation fallout in the air and in the City's water supply.

For the second consecutive year the number of child lead-paint poisoning cases numbered 32, the lowest number in 10 years; the record was marred, however, by the death of one child.

Robert E. Farber, MD
Commissioner of Health

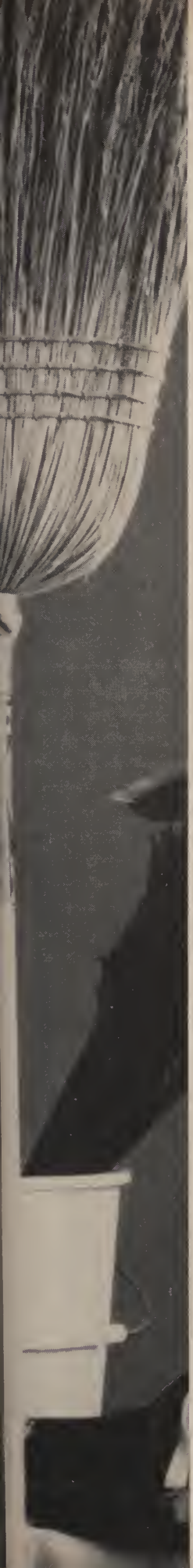
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Indicated in anxiety, tension, agitation, irritability, and anxiety associated with depression.

May be used in a broad range of patients, generally with considerable dosage flexibility.

Contraindications: History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. One patient exhibiting drug dependency by taking a chronic overdose developed upon cessation questionable withdrawal symptoms. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose; excessive prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance. Safety for use in pregnancy has not been established.

Not indicated in children under 6 years; absolute dosage for 6 to 12 year-olds not established.

Side Effects: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leukopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age.

These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever, euphoria and dysmetria.

Availability: Capsules of 10, 15 and 30 mg. oxazepam.

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STATE OF MARYLAND

Department of Mental Hygiene

Isadore Tuerk, MD, Commissioner

Kurt Gorwitz, Statistics Director

Maryland's Mental Hospitals Four Years After Desegregation

Admissions to Maryland's four major mental hospitals were placed on a regional basis in January, 1963. Since that time, the majority of all patients admitted to each of the four have been white. The plan for the desegregation of these facilities, however, did not provide for the transfer of patients already in residence. Since many of these continue to be hospitalized, integration has been gradual and concentrated primarily in the short-term active treatment areas.

PERCENT OF ALL PATIENTS NONWHITE

Date	Total	Crownsville	Eastern Shore	Springfield	Spring Grove
June 30, 1963	23.6	89.0	6.1	4.8	3.0
Dec 31, 1963	23.4	85.9	7.6	6.2	4.5
June 30, 1964	23.3	81.5	8.5	7.6	5.8
June 30, 1965	24.4	75.0	12.8	10.2	8.3
June 30, 1966	25.4	71.9	16.9	12.8	9.5

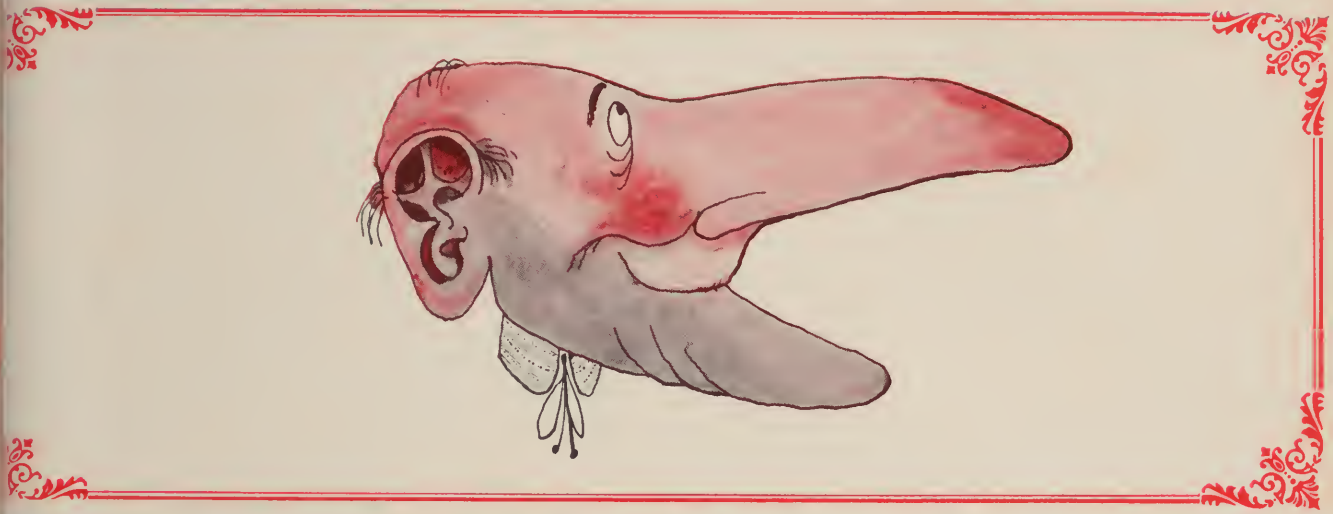
Prior to this change in policy, white admissions had in effect been on a regional basis (to three hospitals) while nonwhite admissions had been limited to one facility (Crownsville). The revision thus brought mental hospitals considerably closer to some segments of the nonwhite population. As a result, although both the number of white and the number of nonwhite admissions have continued to increase, the latter figure has been rising at a faster pace. Latest available data indicate that 28.2% of all patients admitted to the above facilities were nonwhite, as compared with 26.2% reported four years earlier. This change has not been uniformly distributed, however. The nonwhite proportions among patients admitted for psychotic disorders or for alcoholism have remained virtually unchanged (approximately 31% and 25%, respectively); the major change has been among patients admitted for psychoneurotic and personality disorders, the percent of nonwhite having increased from 20.8 to 29.3 during the four-year period.

Proportionally, nonwhite admissions to the State hospitals have continued to be nearly twice as frequent as white. In part, this is related to the concentration of Negroes in Baltimore's inner core slum areas where rates of most types of treated mental illnesses and of other public health problems are substantially above average. In part, also, this reflects the much greater use of alternative psychiatric services (particularly in privately operated hospitals and in private practice) by the white middle class. Since State hospitals are only one of a variety of psychiatric resources available to the community, desegregation of these facilities by itself can therefore not necessarily be expected to provide the opportunity for equal care to meet the needs of all population segments.

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)ICATION: Nasal congestion. CONTRAINDICATION: Do not use patients sensitive to small doses of sympathomimetic substances. \RNINGS: Prolonged or excessive use may cause rebound congesn. Use cautiously in patients with hyperthyroidism, coronary artery ease, hypertension, and diabetes. CAUTION: Do not shake Nasal ray. Rinse Nasal Solution dropper or Nasal Spray tip in hot water er each use. No more than one person should use the same dropper ttle or nasal spray.

)E EFFECTS: Occasional local reactions: rebound congestion, ght burning or stinging, sneezing, dry nose. Occasional systemic ects: headache, drowsiness, lightheadedness, insomnia, palpitans. Overdosage in young children may produce profound sedation.

SAGE: **Adults:** *Nasal Solution*—2 or 3 drops in each nostril every 6 hours. *Nasal Spray*—Squeeze rapidly once or twice in each nosevery 4 to 6 hours. **Children under 12:** *Pediatric Nasal Solution*—in infants under 6 months. *Pediatric Nasal Spray*—Squeeze rapidly once in each nostril holding tube upright; repeat every 4 hours as necessary. SUPPLIED: OTRIVIN® hydrochloride (xylometazoline hydrochloride CIBA) *Nasal Solution*, 0.1%; dropper bottles of 1 fluidounce, bottles of 1 pint. *Nasal Spray*, 0.1%; plastic squeeze tubes of 15 ml. *Pediatric Nasal Solution*, 0.05%; dropper bottles of 1 fluidounce. *Pediatric Nasal Spray*, 0.05%; plastic squeeze tubes of 15 ml. *Nasal Solutions* contain either 0.1% or 0.05% xylometazoline hydrochloride, triethanolamine, hydrochloric acid, sodium chloride, and phenylmercuric acetate 1:50,000 as preservative in water. *Nasal Sprays* contain either 0.1% or 0.05% xylometazoline hydrochloride, potassium phosphate monobasic, potassium chloride, sodium phosphate dibasic, sodium chloride, and benzalkonium chloride 1:5000 as preservative in water. *Consult complete literature before prescribing.*

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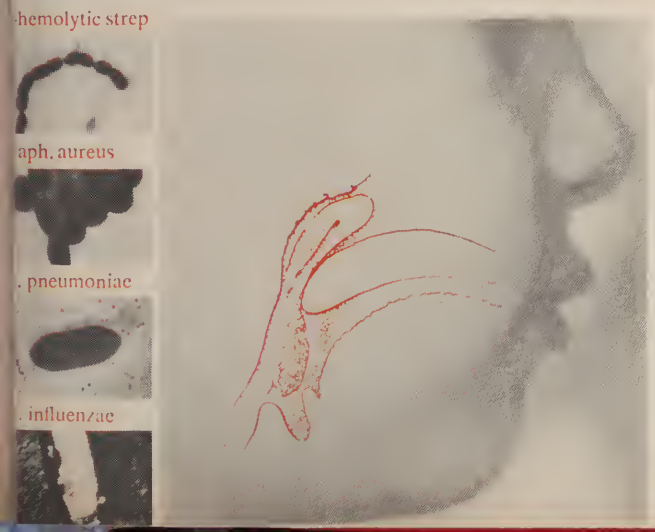

It's easy
for children
to get bacteri
U.R.I....

and Gantanol (sulfamethoxazole) Suspension is a good way to help them get well

roven effectiveness in common bacterial upper espiratory infections

linical results in patients probably much like those you see every ıy show that an overwhelming majority responded favorably to antanol (sulfamethoxazole) Suspension.[1-12] These patients, num-ering over 1600 in published reports, had a variety of bacterial pper respiratory infections such as otitis media, sinusitis, pharyn-tis and tonsillitis, including over 700 cases caused by beta-hemo-tic streptococci.[1-7]

lthough in bacteriologically proven streptococcal infections peni-llin remains the drug of choice, Gantanol (sulfamethoxazole) has own conversion rates comparable to those generally seen with enicillin and apparently superior to those cited in the literature for rythromycin and broad-spectrum antibiotics.[1,2] Conversion rates ave ranged from a high of 96 per cent in 229 patients[2] to a low of 5 per cent in 105 cases.[3,4] When Gantanol (sulfamethoxazole) uspension is used in group A beta-hemolytic streptococcal infec-ons, it is important to continue therapy in the recommended dos-ge for at least 10 days. In addition, Gantanol (sulfamethoxazole) uspension has demonstrated antibacterial activity against *D. pneu-oniae, H. influenzae* and *Staph. aureus*. Thus Gantanol (sulfa-ethoxazole) Suspension may be considered a practical choice for ommon bacterial U.R.I., as well as an effective alternative in the enicillin-sensitive patient with proven beta-hemolytic strepto-ccal infection.



therapy generally uncomplicated by side effects

Such favorable results as those cited in the literature[1-12] are even more meaningful in view of the fact that only 27 of 1961 patients (1.4%) discontinued therapy because of side effects. Of the total side effects reported in 107 patients (5.5%), most were mild and included rash, urticaria, itching, dizziness, headache, diarrhea, nausea and vomiting, shivering sensation, skin discoloration and crystalluria.[1-12]

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute and chronic respiratory and urinary tract bacterial infections due to susceptible microorganisms. At present penicillin is considered the drug of choice in acute group A beta-hemolytic streptococcal infections; however, Gantanol (sulfamethoxazole) has shown an effectiveness approaching that of penicillin in a large number of patients. If employed in such infections, *it is important that therapy be continued in the usual recommended dosage for a period of at least 10 days.*

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants or infants during first 3 months of life.

Warnings: Use only after critical appraisal in patients with liver damage, renal damage, urinary obstruction or blood dyscrasias. If toxic or hypersensitivity reactions or blood dyscrasias occur, discontinue therapy. In intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed. Data insufficient on prolonged or recurrent therapy in chronic renal diseases of children.

Precautions: Observe usual sulfonamide therapy precautions, including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus or rickettsial infections.

Adverse Reactions: Following may occur: headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, Stevens-Johnson syndrome, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Dosage: Children—1 teasp./20 lbs initially, followed by ½ teasp./20 lbs b.i.d. *Adults*—4 teasp. initially, followed by 2 teasp. b.i.d. or t.i.d., depending upon severity of infection.

How Supplied: Suspension 10%, 0.5 Gm sulfamethoxazole/5 cc teasp., cherry-flavored, bottles of 16 oz.

References: 1. Braden, B., and Colmore, J. P.: *J. Oklahoma M.A., 57*:7, 1964. 2. Alban, J.: *Am. J. Dis. Child., 109*:304, 1965. 3. Reichelderfer, T. E.: *Clin. Med., 71*:1045, 1964. 4. Jackson, H.; Cooper, J.; Mellinger, W. J., and Olsen, A. R.: *Southwestern Med., 44*:246, 1963. 5. Braden, B.; Colmore, J. P., and Cummings, M. M.: Antimicrobial Agents Annual—1960, p. 54. 6. Peters, J. H.: Data adapted from a Scientific Exhibit presented at the Spring Meeting of the American Academy of Pediatrics, April 26-29, 1965. 7. Peters, J. H.: Antimicrobial Agents and Chemotherapy—1961, p. 406. 8. Elia, J. C.: *Eye Ear Nose & Throat Month., 41*:722, 1962. 9. Patton, J. M.: *West. Med., 5*:46, 1964. 10. Chastain, P. J.: *J. Florida M.A., 48*:816, 1962. 11. Grater, W. C.: *Antibiotics & Chemother., 12*:450, 1962. 12. Exline, A. L.: *Colorado GP, 5*:(5),11, 1963.

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*Marks, V., and Dawson, A.: Brit. M. J. *1*:293, 1965.



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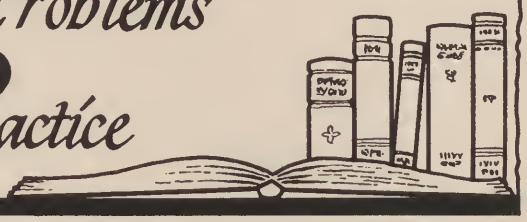
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Telephone Techniques: Part I

WILBURN L. McCLURE, JR.

The telephone can be the single most disruptive influence to a well-planned office routine. Knowledge of proper techniques for coping with this problem can save everyone involved both precious time and wear and tear on the nervous system.

As with many non-medical responsibilities, the aide generally assumes the role of handling the job. Proper coordination is essential, though, if peace and harmony between the doctor and his staff are to remain.

The following can act as a guide toward preparing your office SOP (Standard Operating Procedures) Manual. Revise and extend each category as it best suits your office, *but* remember one thing: KEEP IT UP TO DATE!

Incoming calls from patients: "Good morning. Dr. Morrison's office. Mrs. Philips speaking."

"Hi. This Agnes Leake. May I speak with Dr. Morrison?"

"He is in the office, Mrs. Leake, but at the moment he is examining a patient. May I give him a message and have him take your call as soon as he has finished?"

"No! I want to talk to him right now, sister. Get him on the phone quick!"

"Mrs. Leake, you know I can't interrupt the doctor when he is examining a patient unless it is an absolute emergency. Is this such an emergency?"

"No, dear! I'm sorry. This is not an emergency. I do need his advice, though, right away."

"Thank you, Mrs. Leake. Please hold on."

Sound familiar? Probably. Let's examine what the aide did in the above case. She greeted the patient with a "Good morning" and identified the doctor's office as well as herself. She obtained the patient's name so that she could pull the history file if necessary. She informed the patient of the doctor's immediate status and remained firm when the demands of the patient were unreasonable. Not being able to determine the nature of the patient's problem the first time, she did not press her luck.

In most offices, inquiries similar to the one described above constitute a major portion of incoming calls. How well an aide is prepared to handle these and other inquiries concerning appointments, bills received, cancellations, hospital admission procedures, prescriptions, referrals, etc, determine her value to you and will reflect on her prestige as a professional medical assistant.

Incoming calls of a special nature: "I'm Mr. Long. How's my wife progressing with this pregnancy?"

"Hello. This is Dr. Delp. I would like to re-

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fer a Mrs. Schultz for evaluation. When can Dr. Morrison see her?"

"Rev. Elson speaking. May I speak to Dr. Morrison about giving a lay sermon in June?"

"I'm Capt. Gelson. We'd like to know if Dr. Morrison can sponsor tickets for some boys to go to our Police Boys' Club picnic?"

Special calls like these require special handling, and your assistant may find that all callers are not even this helpful in describing their reasons for telephoning. One thing she will generally recognize immediately is that the caller is not a patient. When this happens, she should obtain pertinent information right away so that she will know what to tell you.

You should make clear to her how you want her to handle incoming calls concerning patient inquiries (from persons other than the patient), patient referrals (by doctors, friends and patients), solicitations, laboratory reports, pharmacies, medical societies, insurance companies and so on.

Incoming calls of a personal nature: "Hello, Mrs. Philips. This is Mrs. Morrison. What's my husband doing?"

"This is Jack Dawson, Dr. Morrison's insurance agent. He asked that I call about this time to discuss a policy."

You can probably make a long list of such calls from members of your family, from lawyers, real estate agents, securities brokers, bankers and the like. Many important personal, as well as business discussions are handled through such calls and, as your ambassador, your assistant should know how you want them processed.

Woman's Auxiliary
MARYLAND
HYGEIA FILIAE
W A M C F

FEBRUARY, 1967

MRS. HARRY L. BERMAN, *Editor*

ALLEGANY COUNTY

Mrs. Robert Dawson, chairman of Health Careers, and her committee have been busy renewing subscriptions to *Today's Health* and replenishing supplies of health careers material, from the American Medical Association and other sources, for nine high schools. The committee is also planning a program to enable students interested in one of the health fields to observe in action those whose careers they would like to emulate.

Students from the American Field Service were guest speakers at the January meeting of the Auxiliary.

The wives of members of the Allegany County Bar Association will be invited to the March meeting of the Auxiliary, at which Carolyn Pincock, MD, will be guest speaker.

BALTIMORE CITY

Mrs. Percy H. Sutley, president of the Auxiliary, has announced that its annual fund-raising luncheon and fashion show will be held at the Greenspring Inn Club on March 6. Reservations are limited and should be made as soon as possible through the Auxiliary treasurer, Mrs. Sullins G. Sullivan, 419 Oak Lane, Baltimore, Md. 21204. Tickets are $5.50 each.

Festivities will begin with a social hour at 11:30 AM. Luncheon will be served at 12:30 PM and the fashion show will start at 1:30 PM. Women's Fashions will come from Octavia of the Village of Cross Keys, children's from the Pied Piper. Furs will be provided by Auman and Werkmeister of North Charles Street, shoes by Hahn's and coiffures by Umberto Salon of Beauty.

Other features of the event will include a raffle, boutique tables, cheer baskets and door prizes.

MONTGOMERY COUNTY

For the seventh consecutive year, the Auxiliary has sponsored two fellowship awards which it presents to the Montgomery County Tuberculosis and Heart Association for use by high school students selected by competitive examination following a lecture series. This year 700 students have enrolled for the lectures. Ten to twelve awards will be given to those who rank highest in the examination, which is optional.

The students who receive the fellowship grants will engage in summer work at the National Institutes of Health and the National Naval Medical Center during a seven-week period beginning in June.

PRINCE GEORGE'S COUNTY

The Auxiliary raised funds for a local nursing scholarship at the annual White Elephant auction in January. Mrs. George Malouf was chairman of the project.

WASHINGTON COUNTY

The Safety Committee is planning a campaign for motorcycle safety, with cash prizes to be awarded for the best poster in each of the high schools and a grand prize to be awarded for the best in the county. The posters will be displayed throughout the area at the end of March.





TABLETS

Equagesic®

(meprobamate and ethoheptazine citrate with aspirin)

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Precautions: Keep out of reach of children. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate may result in dependence or habituation in susceptible persons—as ex-addicts, alcoholics, severe psychoneurotics. Withdraw gradually after prolonged high dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance. If drowsiness, ataxia or visual disturbances occur, reduce dose. If symptoms persist, caution patients against operating machinery or driving. Give cautiously to patients with suicidal tendencies. Treat attempted sulcide with immediate gastric lavage and appropriate supportive therapy

Side Effects: Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness and CNS depression. Overdosage may result in salicylate intoxication. Meprobamate rarely causes allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. Meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioedema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. A few cases of leukopenia, usually transient, have been reported following prolonged dosage. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

Contraindications: History of sensitivity or severe intolerance to aspirin or meprobamate.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

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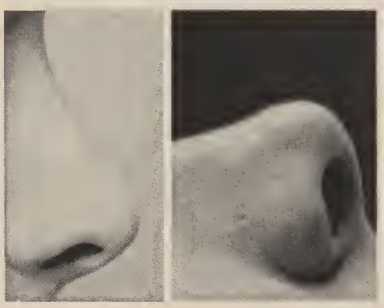
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Appraisal of Rare Books

Since the appearance of the last LIBRARY PAGE in the December issue of THE JOURNAL, a significant step has been taken in the development of the Med-Chi Library. As the result of a decision by the Library Committee at its November meeting, Mr. Lee Ash, well-known library consultant and authority on rare medical books, was invited to make a preliminary survey of the Library collection with the eventual aims of appraising the rare books and recommending the best method of disposition of duplicates and obsolete textbooks. Recently, several medical school libararies have realized as much as $70,000 from the sale of such items!

In January, Mr. Ash spent two days looking over our shelves and in a very short time spotted quite a few titles of value. Some of these were on the open stack shelves, since our present "Rare Book Room" is about the size of an enlarged coat closet and extremely inadequate.

For some time it has been the desire of the Library Committee, and other interested members of the Faculty, to establish a Rare Book Room. Such a room should provide not only the necessary space to accommodate the collection, but also protection against fire and theft and the correct environment for the preservation of rare bindings and papers. In addition, there should be a reading area for study and research, as well as office and work space.

Library Personnel

In as much as medical librarians, along with all other special librarians, are very scarce, it behooves all of us interested in recruiting new personnel for the field to encourage any young persons with an aptitude for the profession. Career information is available from the Medical Library Association, 919 North Michigan Avenue, Chicago, Illinois, 60611, or from this Library.

RECENT ACCESSIONS

(Arranged by call number)

QM 531 H6 1954-1958
Hollinshead, William Henry

Anatomy for surgeons. New York, Hoeber-Harper, 1954-58.

R 154 B3 S4
Selleck, Henry B

Beaumont and "The Mackinac Island Miracle." Michigan, East Lansing, 120 W Saginaw Street, (no date).

R 856 Y3 1965
Yanof, Howard M

Biomedical electronics. Philadelphia, F. A. Davis Co., 1965.

RA 407 S4 1964
Shindell, Sidney

Statistics, science, and sense. Pittsburgh University of Pittsburgh Press, 1964.

RA 410 M2 1966
McNerney, Walter J

Hospital and medical economics, a study of population, services, costs, methods of payment, and controls, by Walter J. McNerney and study staff, the University of Michigan. Chicago, Hospital Research and Educational Trust, 1962.

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Washington and New York offices, also

RC 46 M2 1965
McCombs, Robert Pratt

Internal medicine; a physiologic and clinical approach to disease. 2d ed. Chicago, Year Book Publishers, 1960.

RC 87 Y6 1965
Young, Carl B

First aid for emergency crews; a manual on emergency first aid procedures for ambulance crews, law enforcement officers, fire service personnel, wrecker drivers, hospital staffs, industry, nurses. Foreword by Robert H. Kennedy. Illustrated by Alfred Hesse. Collaborating physician: Roger S. Knapp, Springfield, Ill., C. C. Thomas, 1965.

RC 111 L3 1965
Lawson, James H

A synopsis of fevers and their treatment. Rev. by James H. Lawson. 11th ed. Chicago, Year Book Medical Publishers, 1965.

RC 377 M2 1965
McAlpine, Douglas

Multiple sclerosis; a reappraisal by Douglas McAlpine, Charles E. Lumsden and E. D. Acheson. Baltimore, Williams and Wilkins, 1965.

RC 570 S7 1964
Stevens, Harvey A

Mental retardation; a review of research, edited by Harvey A. Stevens and Rick Heber. Chicago, University of Chicago Press, 1964.

RC 685 J8f 1965
Jude, James R

Fundamentals of cardiopulmonary resuscitation by James R. Jude and James O. Elam. Illus. by Matthew A. Monks. Philadelphia, F. A. Davis Co., 1965.

RD 521 P6 1961
Postlethwait, Raymond W

Surgery of the esophagus, by Raymond W. Postlethwait and Will Camp Sealy. Springfield, Ill., C. C. Thomas, 1961.

RD 768 S4 1962
Shapiro, Robert

Myelography. Chicago, Year Book Medical Publishers, 1962.

RG 77 M3 1966
Marcuse, Peter M

Diagnostic pathology in gynecology and obstetrics. New York, Hoeber Medical Division, Harper & Row, 1966.

RJ 42 P7 1962
Provence, Sally A

Infants in institutions: a comparison of their development with family-reared infants during the first year of life by Sally Provence and Rose C. Lipton. Pref. by Milton J. E. Senn. New York, International Universities Press, 1963.

RJ 499 R5 1964
Rimland, Bernard

Infantile autism; the syndrome and its implications for a neural theory of behavior. New York, Appleton Century-Crofts, 1964.

RJ 45 S7 1966
Stowens, Daniel

Pediatric pathology. 2d ed. Baltimore, Williams & Wilkins Co., 1966.

RK 501 M7 1965
Moore, J R

Principles of oral surgery. 1st ed. Oxford, New York, Pergamon Press, 1965.

RM 849 D4 1965
Dewing, Stephen B

Radiotherapy of benign disease, by Stephen B. Dewing. With a chapter on Radiotherapy of benign skin diseases by Ralph Wier Grover. Springfield, Ill., C. C. Thomas, 1965.

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*Brest, A. N., et al.:J. New Drugs 5:329, 1965.

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References: 1. Pillsbury, D. M., Shelley, W. B., and Kligman, A. M.: A manual of cutaneous medicine, Philadelphia, Saunders, 1961, p. 79. **2.** Barber, M., and Garrod, L. P.: Antibiotic and chemotherapy, Baltimore, Williams and Wilkins, 1963, p. 111.

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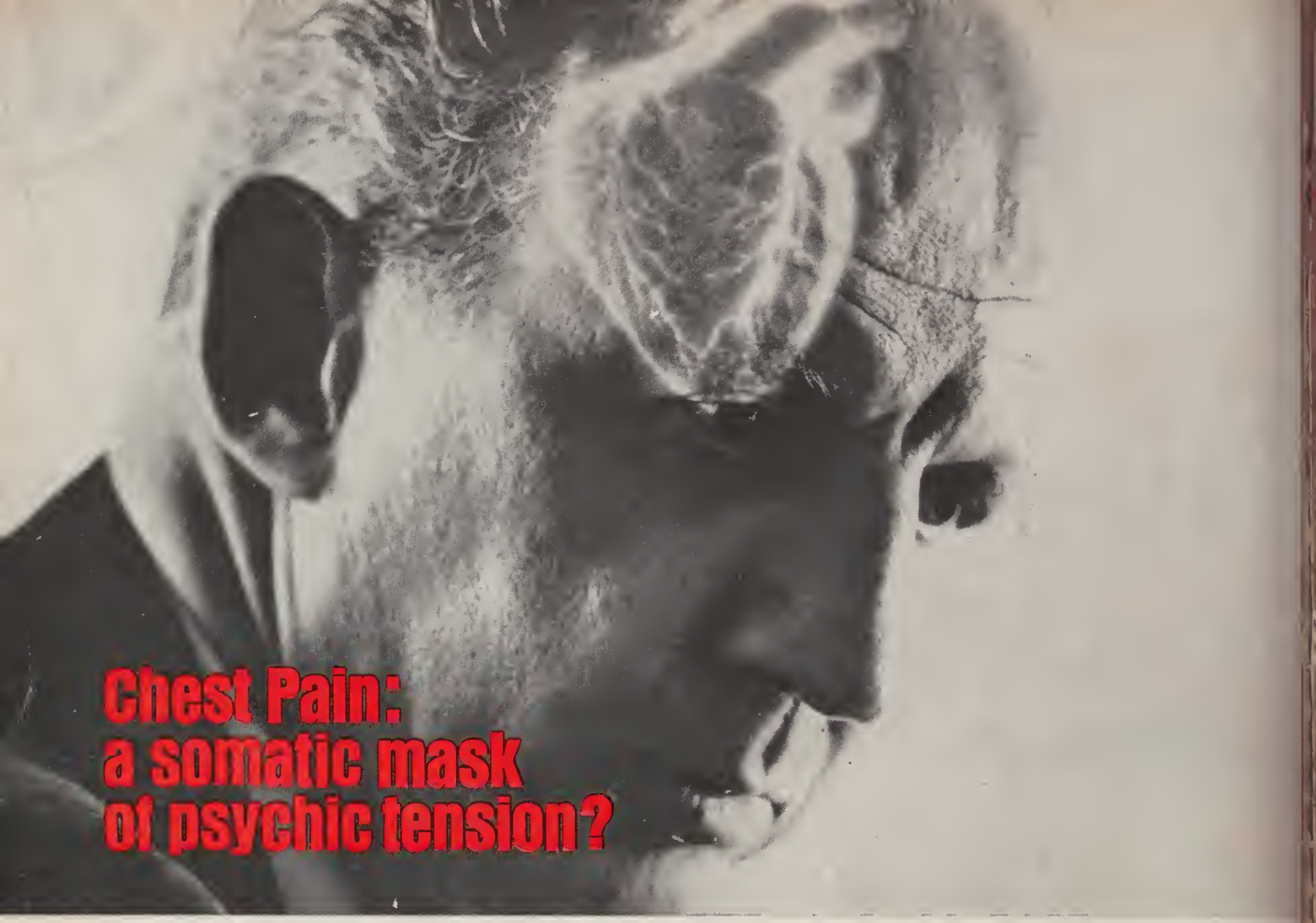
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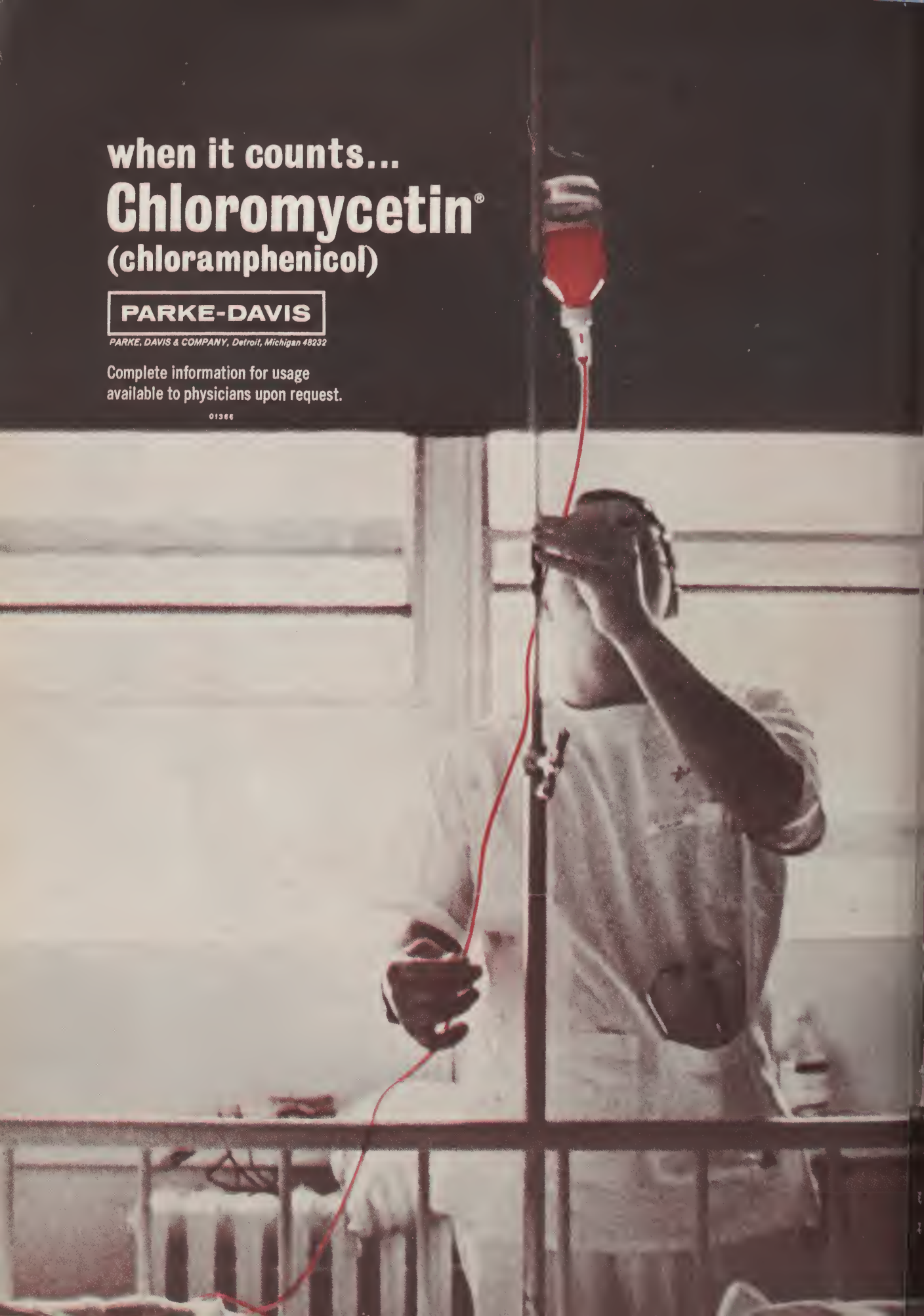
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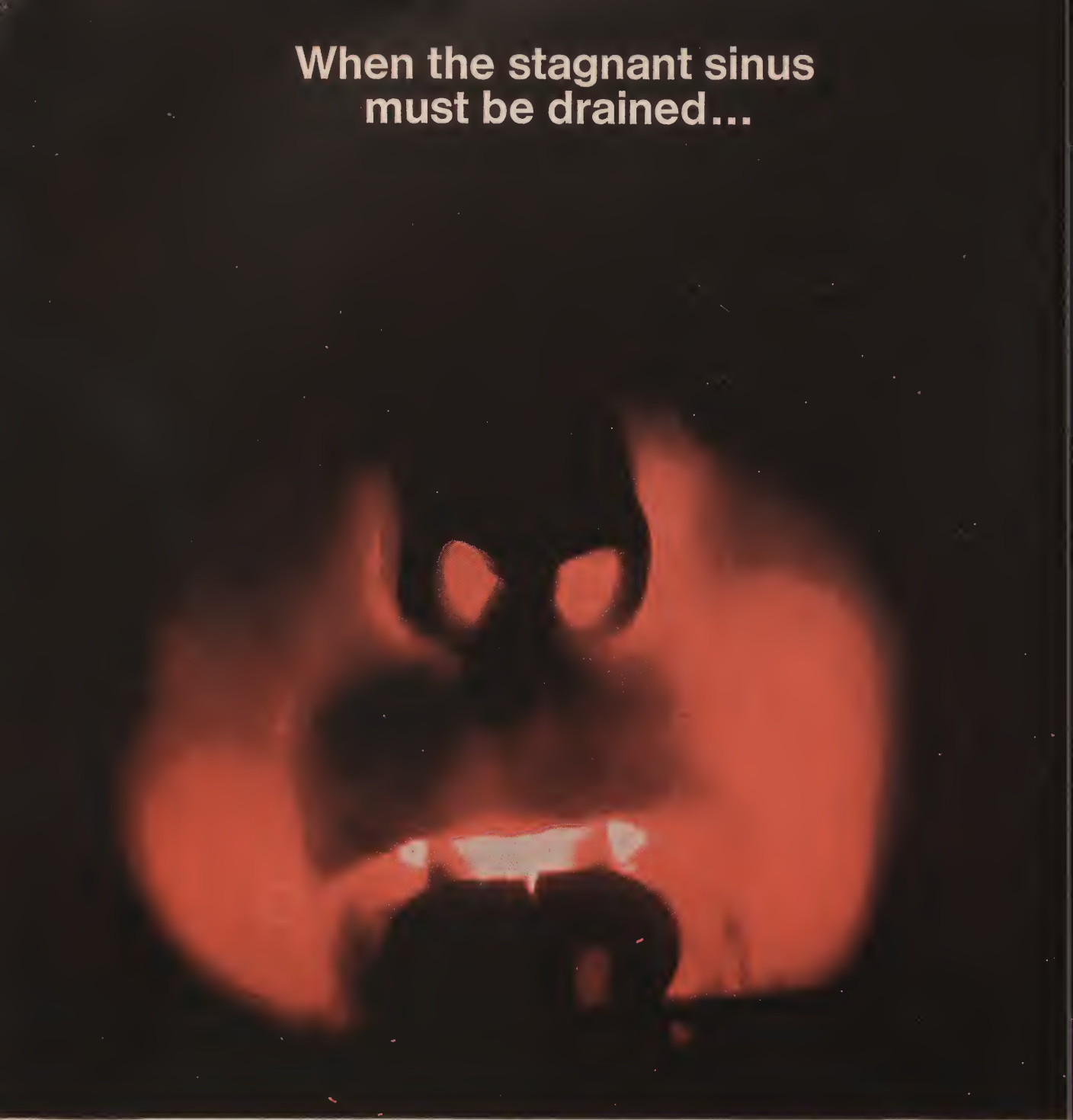
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When the stagnant sinus must be drained...



Transillumination of the sinuses—diffuse shadow on right side of face indicates unilateral maxillary sinusitis.

In the common cold, Neo-Synephrine is unsurpassed for reducing nasal turgescence. It stops the stuffy feeling at once. It opens sinus ostia to re-establish drainage and lessen the chance of sinusitis. With Neo-Synephrine, in the concentrations most commonly used, decongestion lasts long enough for extended breathing comfort, without endangering delicate respiratory tissue. Systemic side effects are virtually unknown. There is little rebound tendency.

Winthrop Laboratories, New York, N.Y. 10016 Winthrop

Neo-Synephrine® HCl

Brand of phenylephrine hydrochloride

is available in a variety of forms, for all ages:

- ⅛% solution for infants
- ¼% solution for children and adults
- ¼% pediatric nasal spray for children
- ½% solution for adults
- ½% nasal spray for adults
- ½% jelly for children and adults
- 1% solution for adults (resistant cases)

Also NTZ® Solution or Spray
Antihistamine-decongestant

(1025M)

Maryland
STATE MEDICAL JOURNAL

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Vol. 16, No. 3
March, 1967

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What you should know about
CONSOLIDATED MEDICAL SERVICES

What is it?

Consolidated Services is an operation designed to pay the physician's fees immediately through centralized billing and collection, thus permitting him and his staff to devote complete attention to the performance of physician services. Consolidated Services is owned and operated by a group of prominent doctors and businessmen, and is governed in accordance with strict ethical standards by a committee of investor/participants.

How does it work?

At a billing time convenient to the physician, he provides his receptionist with patients' names, services rendered, and fees due. Using a touch-tone card dialer, supplied and installed by Consolidated Services, the receptionist transmits the data to the central office, by means of pre-punched cards employing a numerical code. The transmission is completed in seconds . . . and one week from billing date, Consolidated remits fully to the physician, less a modest discount. The touch-tone card dialer is used as your regular office telephone; no other telephones are necessary with this unit. Pre-punched cards are supplied at no cost.

How does the physician benefit?

Billing by Consolidated Services places the physician on an immediate full cash basis. For example, if a physician bills $5000 on September 1, research states that only 40 to 50 per cent will be collected that month, resulting in $2500 cash on hand and $2500 remaining in accounts receivable. But when using Consolidated Services, the physician collects the full $5000 within a week, in addition to eliminating costly billing, stationery, postage, and clerical time. Conservative investment of the additional $2500 collected would virtually cover the modest cost of the service.

What about payment plans?

Consolidated offers five different plans:

Basic Billing on physician's choice of personal statement or third party bill head. Patient has option of 90 day payment at no extra charge.

Patient Option Plan I. Straight six-month plan, 1% per month service charge on declining balance.

Patient Option Plan II. Twelve-month plan, service charge 1½% per month.

Professional Option Plan III. Six month; no service charge to patient. 1% flat charge to physician, plus discount.

Professional Option Plan IV. Twelve month; no service charge to patient. Physician pays 2% flat charge, plus discount.

How much will it cost me?

Consolidated applies a service charge of 5 to 7% dependent upon size and volume of the practice. This is in the form of a discount on remittances; for example, if Dr. Jones reports patients' fee amounting to $100, he receives a check for $93 or more within a week. There are no hidden costs in Consolidated's program. All costs for installation of touch-tone dialer, patient data cards, forms, reports, etc., are absorbed by Consolidated Services.

How can I become a participant?

By calling our Executive/Control Offices, 486-4984/8935 and requesting an appointment. We will be pleased to serve you promptly.



CONSOLIDATED MEDICAL and DENTAL SERVICES, Inc.

Executive/Control Offices

9113 Reisterstown Road Garrison, Maryland 21055

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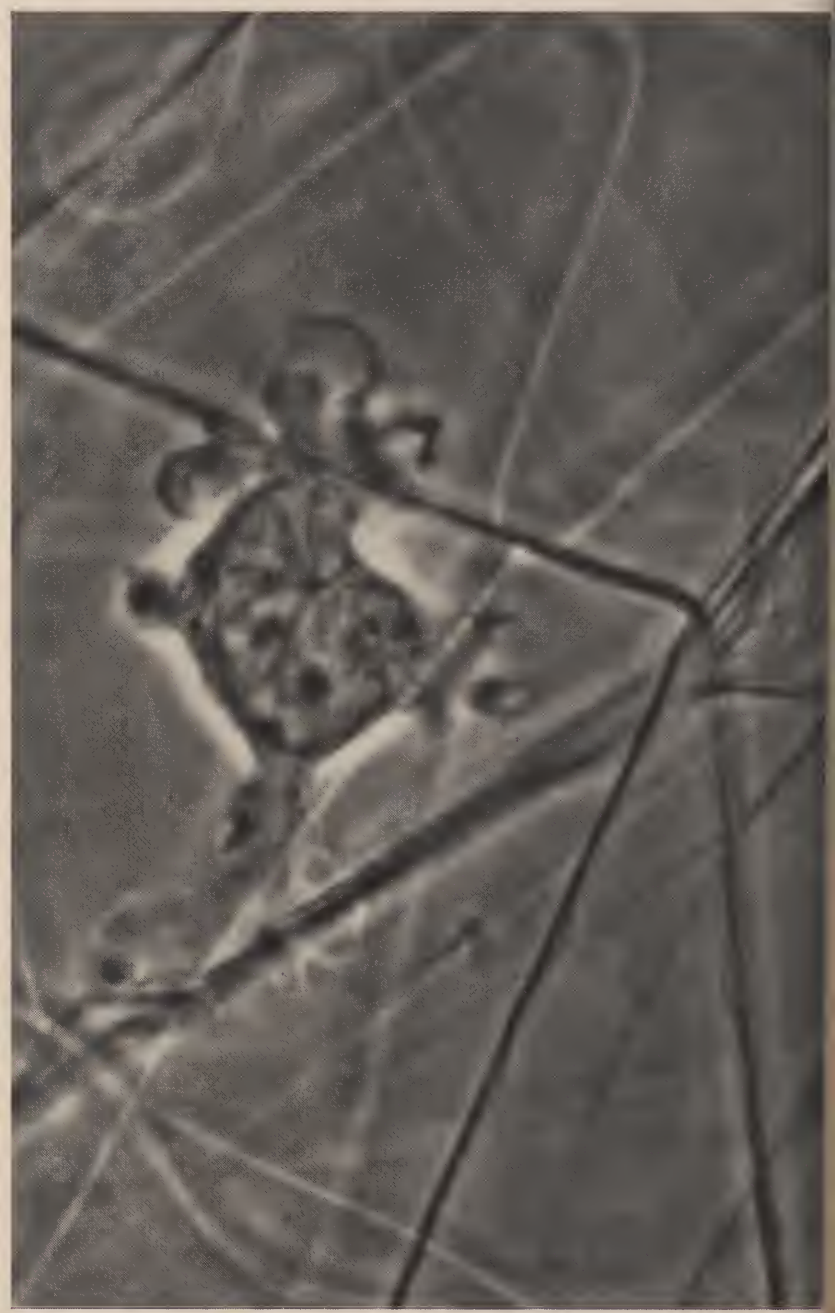
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INFLAMMATION:
A cellular fight for life

A SYNTEX REPORT based on recently developed hypotheses about topical corticosteroids, including the cellular theories of inflammation by Thomas F. Dougherty, Ph.D., University of Utah.

You are looking at a fibroblast fighting for life. This cell—one of the most common found in connective tissue—has literally been poisoned by cytotoxins released from other cells that have ruptured. Soon, if the abnormal activity of this fibroblast does not cease, it, too, will rupture and die—one more casualty in the inflammatory wave of destruction precipitated by injury.

Until a short time ago no one had ever witnessed such a scene at the cellular level. Now, through advanced cinemicrographic techniques, it is possible to view and photograph the inflammatory process as produced experimentally in living animal tissue. This method permits new insight into the mechanism of inflammation and the role of corticosteroids in therapeutic management. Equally important, these techniques shed new light on factors that may make one corticosteroid more effective than another—factors that can be correlated with other chemical, biologic, and clinical parameters.

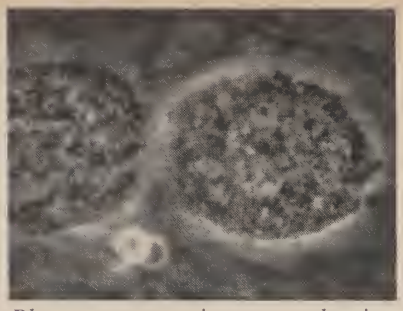


Visual evidence of how corticosteroids influence the inflammatory reaction

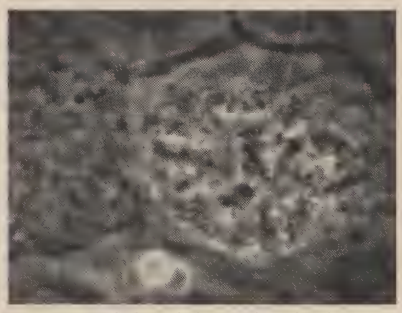
Working with phase-contrast cinemicrography on living animal tissue, Doctors Thomas F. Dougherty and David Berliner of the University of Utah College of Medicine have actually filmed cellular events that occur during the inflammatory reaction. This remarkable study* and additional work by these investigators, as well as by others, have established a new theoretical biologic basis for the antiinflammatory effect of the corticosteroids. (It must be noted that other theories, such as the lysosome or so-called "suicide bag" theory, have been postulated, although it is quite likely that there are more similarities than differences among the various theoretical models.)

The inflammatory wave of destruction

In this investigation an injurious injection of gelatin is used to set off an inflammatory reaction in living mouse tissue. What follows is a wave of destructive cellular activity that comprises the inflammatory response to injury. Mast cells (which contain heparin, serotonin and histamine) take up water, swell and rupture, releasing their contents, which are toxic outside the mast cell wall. These toxins, in turn, cause disintegration of other cells (such as fibroblasts) and the release of additional toxic material. Capillaries, too, take up water and leak unformed blood elements, causing edema. And polymorphonuclears, lymphocytes and perithelial cells invade the inflamed site. As a result of all these changes, the cellular environment reaches a state of turmoil.



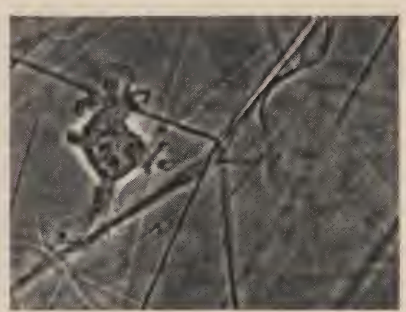
Phase-contrast microscopy showing mast cell before injury.



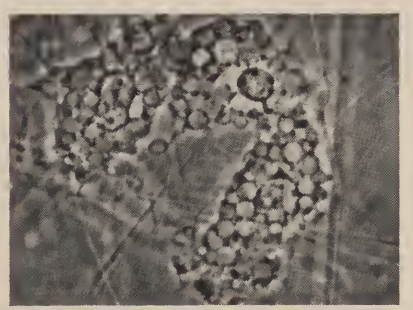
Mast cell (after injury) has broken up and released cytotoxins.

How corticosteroids change the picture

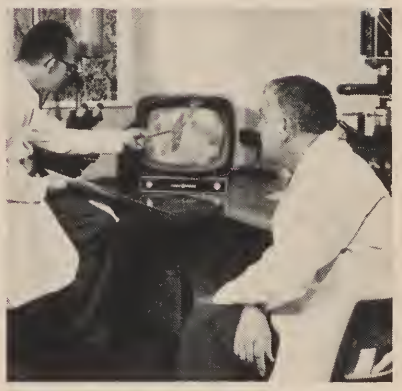
Corticosteroids appear to virtually stop the abnormal cellular activity that constitutes the inflammatory reaction. This permits the body's natural resources to clear up the inflamed area and repair the damaged tissue. This interpretation is supported by the fact that when the injurious gelatin solution is injected simultaneously with a corticosteroid —Synalar (fluocinolone acetonide)— the inflammatory pattern simply does not develop.



Fibroblast in high state of activity, much distorted.



Mast cells showing effects of corticosteroid action: cells are normal in size, shape and activity.



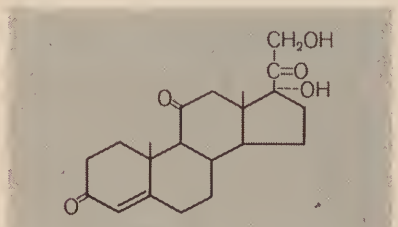
In summarizing his study Doctor Dougherty states: "...we also feel this work may explain why one corticosteroid helps a patient more rapidly and effectively than another. If it does, it is because one corticosteroid is the fastest, most effective inhibitor of the series of inflammatory events at the tissue level."

**A New View of Corticosteroid Action in Inflammatory Dermatoses,* a film based on this study, is now available from your Syntex representative.

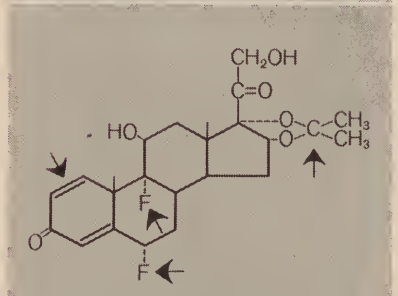
See last page for contraindications, precautions, side effects and dosage.

How advances in chemical design have achieved greater steroid potency

The chemical modification of corticosteroid molecules from the advent of hydrocortisone to the development of Synalar (fluocinolone acetonide) is a prime example of how biochemists can "design" to increase therapeutic activity and minimize undesirable side actions. Below, for example, we see the important changes that were made in reference to the hydrocortisone molecule to produce fluocinolone acetonide, one of the most active of all topical corticosteroids. As a result, a 0.01% preparation of Synalar (fluocinolone acetonide) has been reported to do the work of a 1% hydrocortisone product containing 100 times more cortiscosteroid. And it can often do it more effectively.



Hydrocortisone

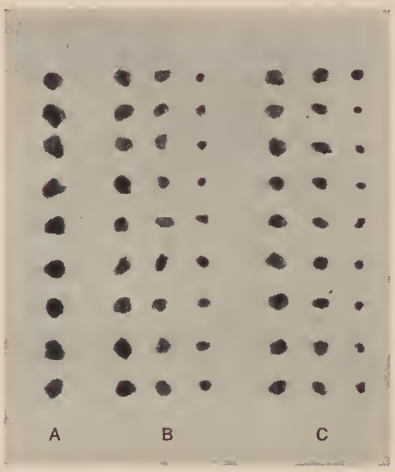


Fluocinolone Acetonide (Synalar)

- *a double bond between carbons 1 and 2*
- *fluorine substitutions at* both *the 6-α, and the 9-α positions*
- *the addition of the acetonide at the 16-α, 17-α positions, thus providing one of the most potent topical corticosteroids available.*

How bioassay tests are used to "predict" therapeutic potential

Biologic assays are another tool used by researchers to help establish the relative activity of corticosteroids. To date no single method of assaying corticosteroid activity has emerged as the ideal "yardstick" for predicting therapeutic potential. Taken together, however, these methods have proved useful. When such tests are run on various corticosteroids, a definite order of corticosteroid activity becomes evident. Compounds with the highest order of activity may be expected to merit clinical trial to establish their high therapeutic potential. When assayed by these methods, fluocinolone acetonide (Synalar) emerges as one of the most active topical corticosteroids, milligram for milligram, available for clinical application today.



THE THYMUS INVOLUTION ASSAY[1-4] is run on adrenalectomized rats. The sizes of the glands are measured, and the degree of involution caused by the steroid is determined as an indication of its potency. In the above photo, the comparative involution of thymus glands achieved with hydrocortisone and Synalar (fluocinolone acetonide) is shown. Untreated controls (A) show normal size. Group B – injected with 1, 2 and 4 mg. of hydrocortisone – show progressively smaller thymuses as does Group C – injected with fluocinolone acetonide – but with only 1/500th the dose of hydrocortisone.



THE ANTIGRANULOMA ASSAY[1-4] also utilizes adrenalectomized rats. Granulomas are induced by subcutaneous implantation of cotton pellets on either side of the thorax. The degree of granuloma inhibition achieved by a steroid reflects its potency. The above photo shows the inhibition of granuloma formation achieved with hydrocortisone and Synalar (fluocinolone acetonide). Untreated controls (A) show large, red granulomas adhering to the pellets. Group B, receiving hydrocortisone and Group C, receiving fluocinolone acetonide, show little, if any, granuloma formation. Fluocinolone acetonide produced the same effect as hydrocortisone with only 1/500th the dose. This assay, as well as the thymus involution assay, measures systemic rather than topical corticosteroid activity. Nevertheless, results by these methods correlate well with other assays and with the milligram potencies of topical steroids in current clinical use.

Worldwide clinical experience confirms the predictable therapeutic potential of Synalar

It is particularly gratifying that the promise of the advanced chemical design and high order of bioassay activity of Synalar (fluocinolone acetonide) has been confirmed by widespread therapeutic application. Indeed, the impressive clinical response rate of Synalar has been documented in no fewer than 232 papers from 22 countries.

Representative Clinical Results with Synalar*

Efficacy Documented in over 4,000 Patients

Condition	Number of Publications	Number of Patients	Significant Improvement†
Contact Dermatitis	27	750	713
Eczematous Dermatitis	21	472	409
Seborrheic Dermatitis	18	442	426
Atopic Dermatitis	24	460	426
Psoriasis	36	1,699	1,510
Neurodermatitis	18	351	324
Total	144	4,174	3,808

*Complete bibliography on request.

†Expressed by the authors as excellent, very good, good, complete remission of inflammation, etc.

PRESCRIBING INFORMATION

For initiation of therapy: Cream 0.025%, 5 and 15 Gm. tubes, 425 Gm. jars; *for emollient effect:* Ointment 0.025%, 15 Gm. tubes; *for maintenance therapy:* Cream 0.01%, 15 and 45 Gm. tubes, 120 Gm. jars; *for intertriginous or hairy sites:* Solution 0.01%, 20 cc. and 60 cc. plastic squeeze bottles; *for infected inflammatory dermatoses:* Neo-Synalar® Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes.

CONTRAINDICATIONS: Tuberculous, fungal, and most viral lesions of the skin, (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. PRECAUTIONS: Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. When severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. SIDE EFFECTS: Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. The neomycin in Neo-Synalar Cream rarely produces allergic reactions.

REFERENCES: 1. Lerner, L. J., Bianchi, A., Turkheimer, A. R., Singer, F. M., and Borman, A.: Anti-inflammatory steroids: potency, duration and modification of activities. Ann NY Acad Sci 116:1071 (Aug. 27) 1964. 2. Idem: Comparison of anti-granuloma, thymolytic and glucocorticoid activities of anti-inflammatory steroids. Proc Soc Exp Biol Med 116:385 (June) 1964. 3. Ringler, A.: Activities of adrenocorticosteroids in experimental animals and man, in Dorfman, R. I.: Methods of hormone research, New York, Academic Press, 1964. vol. III. pp. 234-280. 4. Gubersky, V. R.: To be published.

fluocinolone acetonide — an original steroid from

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LABORATORIES INC., PALO ALTO, CALIF.

For inflammatory dermatoses... by any measure a topical corticosteroid of choice

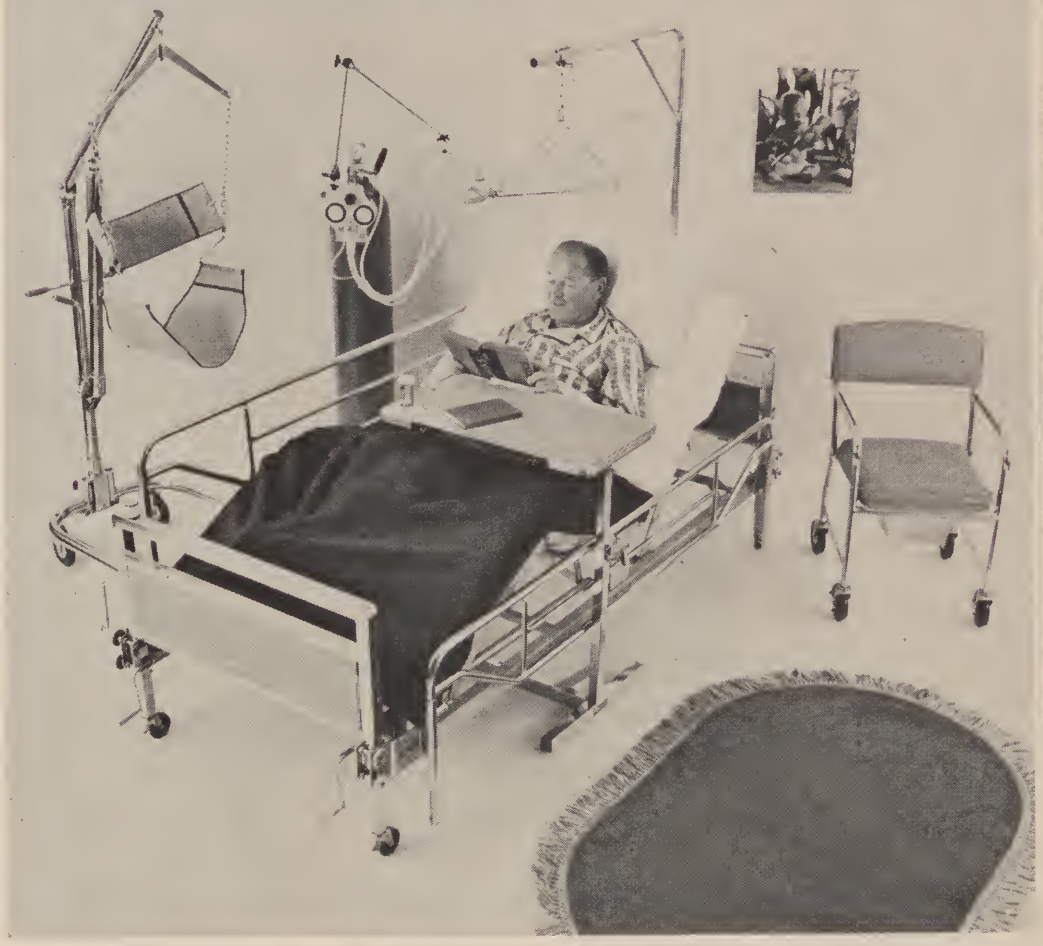
Synalar® (fluocinolone acetonide)

Milligram for milligram one of the most active topical corticosteroids available

Rapid and predictable in antiinflammatory and antipruritic activity

Results often comparable to those of systemic corticosteroids with fewer hazards

A complete hospital room at home is now available under MEDICARE and LOCAL AID



All your patient need do is call Abbey for any item on your verbal or written authorization. Abbey completely processes all MEDICARE and LOCAL AID equipment claims, including hospital beds, wheelchairs, traction and oxygen equipment, crutches, walkers, commodes, lamps, whirlpools, and all other authorized items. We have 42 years of experience behind us to fit the equipment to the patient's precise needs. Professional service 24 hours a day every day, with prompt delivery by trained technicians.

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BALTIMORE

Doctors take note...

MEDIC

FRIDAY POSTGRADUATE PROGRAMS

See page 163 for list of locations where MEDIC programs may be heard)

March 31, 12:30 PM

The Effective Use of a Pathology Service

Thomas M. Peery, MD, Professor of Pathology and Director Laboratory Service, George Washington University Medical School.

April 7, 12:30 PM

Open Heart Surgery—Preoperative Evaluation of Patients With Acquired Heart Disease

R Adams Cowley, MD, Professor and Head, Division of Thoracic Surgery, University of Maryland School of Medicine.

April 14, 12:30 PM

Population Dynamics

Paul A. Harper, MD, Professor of Maternal and Child Health and Population Dynamics, The Johns Hopkins University School of Hygiene.

April 21, 12:30 PM

Population Control

Hugh J. Davis, MD, Assistant Professor of Gynecology and Obstetrics, The Johns Hopkins University School of Medicine.

April 28, 1 PM

Concepts in Treatment of Adrenocortical Dysfunction

Col. William Beisel, MC, Walter Reed Unit, Fort Detrick Army Hospital.

GRAND ROUNDS VIA MEDIC

(The following programs may be heard at network hospitals only.)

Tuesday, March 28; April 4, 11, 18, 25
11:30 AM-1:00 PM—MEDICAL GRAND ROUNDS
from University Hospital

Friday, March 31; April 7, 14, 21, 28
2:00 PM-3:00 PM—NEUROLOGY GRAND ROUNDS
from University Hospital

Saturday, March 25; April 1, 8, 15, 22, 29
8:00 AM-9:00 AM—PEDIATRIC GRAND ROUNDS
10:00 AM-11:30 AM—MEDICAL GRAND ROUNDS
from the Johns Hopkins Hospital

REFERENCE COMMITTEE MEETING

March 29, 8 PM

1211 Cathedral Street **Baltimore**

All members of the Faculty are invited to attend this meeting, the purpose of which is to consider Resolutions to be proposed at the Annual Meeting of the House of Delegates.

Copies of the Resolutions to be discussed are available at the Faculty office.

Third Annual Conference

FRIENDS OF PSYCHIATRIC RESEARCH, INC.

March 30, 1 PM-6 PM

Symposium: Drugs and the Brain

Sheraton-Belvedere Hotel, Baltimore

For information, write or call: Richard H. Meacham, administrator, Friends of Psychiatric Research Inc., 52 Wade Avenue, Baltimore, Md 21228; 747-0243.

MARYLAND EAR, NOSE AND THROAT SOCIETY

April 4, 7:30 PM

Headaches, Diagnosis and Treatment

Raymond L. Hilsinger, MD, assistant professor of otolaryngology, University of Cincinnati College of Medicine.

Sheraton-Belvedere Hotel, Baltimore

MARYLAND PSYCHIATRIC SOCIETY

April 13

Brief Psychotherapy

Harvey J. Tompkins, MD, president, American Psychiatric Association.

1211 Cathedral Street, Baltimore

MARYLAND OPHTHALMOLOGICAL SOCIETY

March 30

Cocktails 6:00 PM, Dinner 7:00 PM, Speaker 8:00 PM

Trends in Cataract Surgery

R. M. Fasanella, MD, New Haven, Conn.

Sheraton-Belvedere Hotel, Baltimore

MARYLAND RADIOLOGICAL SOCIETY

April 18, 5:30 PM

Residents' Papers

Sheraton-Baltimore Inn, Baltimore

SYMPOSIUM ON PSYCHOTROPIC DRUGS: USE AND ABUSE

April 12, 1:30 PM-5:00 PM

1:30 PM Introduction and Greeting

1:40 PM Antidepressant Agents

Joseph R. Cowen, MD, attending psychiatrist, Department of Psychiatry, Sinai Hospital of Baltimore, Inc. DISCUSSANTS: Martin Gross, MD; Albert A. Kurland, MD; and Bernard R. Shochet, MD.

2:30 PM Coffee Break

2:40 PM Anti-Anxiety Agents

Albert A. Kurland, MD, director of research, State Department of Mental Hygiene.
DISCUSSANTS: Martin Gross, MD; Bernard R. Shochet, MD; and Joseph R. Cowen, MD.

3:30 PM Coffee Break

3:40 PM Anti-Psychotic Agents

Martin Gross, MD, director of research, Springfield State Hospital.
DISCUSSANTS: Albert A. Kurland, MD; Joseph R. Cowen, MD; and Bernard R. Shochet, MD.

4:30 PM Summary, and Question and Answer Period

Sponsored by the Department of Psychiatry, Sinai Hospital of Baltimore, Inc., and the Maryland Chapter, American Academy of General Practitioners; supported by the Hoffman-Roche Pharmaceutical Company.

3 hours AAGP credit, Category I

Parking provided—Levindale Parking Lot

The Zamoiski Auditorium—Sinai Hospital Baltimore

BALTIMORE CITY MEDICAL SOCIETY SEMI-ANNUAL BUSINESS MEETING

April 7, 8:30 PM

Election of new members, review of business to be transacted at the annual meeting of the Faculty House of Delegates, and other new business.

1211 Cathedral Street Baltimore

DID YOU ATTEND THE FEBRUARY 3 AND MARCH 3 BCMS MEETINGS?

They are acceptable for 2 hours of AAGP credit, Category I. If you wish to establish such credit, call the secretary at LE 9-4096.

PHILADELPHIA COUNTY MEDICAL SOCIETY

April 11-14

31st Annual Postgraduate Institute covering twelve different subjects

Bellevue-Stratford Hotel, Philadelphia

Approved for credit by AAGP

Registration: $15 per day $50 for entire period

For information, write: Robert L. Mayock, MD, director, PCMS, 2100 Spring Garden St., Philadelphia, Pa. 19130

JOINT ANESTHESIA STUDY COMMITTEE

April 25, 7:30 PM

Meeting of the Joint Anesthesia Study Committee of the Baltimore City Medical Society and the Baltimore City Health Department.

1211 Cathedral Street, Baltimore

4th AMA CONGRESS ON ENVIRONMENTAL HEALTH PROBLEMS

April 24-26

Americana Hotel, New York City

Co-sponsored by the Medical Society of the State of New York, the New York State Action for Clean Air Committee, and the New York State Department of Health

For information, write: Dept. of Environmental Health, American Medical Association, 535 North Dearborn St, Chicago, Ill. 60610.

WATCH YOUR MED-CHI MAIL IN APRIL!

With your Legislative Newsletter, *The Assemblyman*, you will receive a light blue return-postcard. What you do with the postcard will determine how you will be listed in the **1967 MEMBERSHIP DIRECTORY**

1967 AMERICAN INDUSTRIAL HEALTH CONFERENCE

April 10-13

Americana Hotel, New York City

Sponsored by the Industrial Medical Association and the American Association of Industrial Nurses

For information, write: American Industrial Health Conference, 55 East Washington St., Chicago, Ill. 60602.

CANCER PROGRAM WORKSHOP

April 21

THEME: Why your hospital needs a Cancer Program

Medical College of Virginia, Richmond

For information, write: Concer Program Activities, American College of Surgeons, 55 Eost Erie Street, Chicago, Ill 60611.

TENTH ANNUAL JOINT CARDIAC SYMPOSIUM

April 27

Sponsored by the Heart Associotion of Northern Virginia, Inc., and the Woshington Heart Associotion

Marriott Twin Bridges Motor Hotel, on US Route 1, Washington, DC

For information, write: Mrs. Anna C. Von Sickler (executive director, HANV), 609 North Edgewood St., Arlington, Va. 22201

INTERNATIONAL COLLEGE OF SURGEONS

32nd ANNUAL CONGRESS

April 30-May 4

Americana Hotel, Bal Harbour, Florida

For information, write: Stanley E. Henwood, executive director, ICS, 1516 Loke Shore Dr, Chicogo, Ill 60610.

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

15th Annual Clinical Meeting

April 17-20

Hilton Hotel, Washington, DC

AMERICAN CANCER SOCIETY

May 3

1967 Scientific Session

Theme: Current Concepts in Etiology ond Diagnosis of Concer

Open to all members of the medical profession and to all medicol students—no registration fee

Sheraton-Dallas Hotel, Dallas

201st ANNUAL MEETING THE MEDICAL SOCIETY OF NEW JERSEY

May 13-17

Haddon Hall, Atlantic City, NJ

No registrotion fee for out-of-state non-member physicians—Maryland physicians are cordially invited.
For information, write: MSNJ, P.O. Box 904, Trenton, NJ 08605.

THREE-STATE CONFERENCE ON AIR RESOURCE MANAGEMENT

May 15-16

City College New York, NY

The first attempt to develop o blueprint for community action against air pollution on an interstate basis, the conference will focus on the New York-New Jersey-Connecticut metropoliton complex. The three state heolth commissioners are omong the members of the Conference Board, of which Norman Cousins is chairman.

For information, write: Prof. Richard G. Coulter (conference coordinator), Department of Engineering, The City College, 138th St. ond Convent Ave., New York, N.Y. 10031

LOOK TO THE ULTIMATE IN NURSING HOMES

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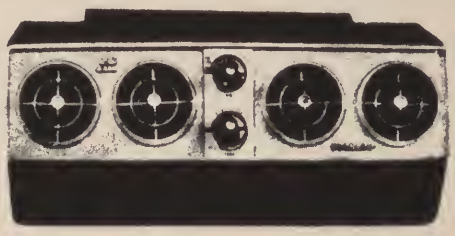


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For information, write: Director of Medical Education, American Heart Association, 44 East 23rd St., N.Y., N.Y. 10010.

CLINICAL ELECTROENCEPHALOGRAPHY

June 5-7

A second course for physicians who have had little or no formal EEG training, to be conducted in Philadelphia under the sponsorship of the EEG Society, aided by a grant from the Bureau of State Services, US Public Health Service.

For information, write: Donald W. Klass, MD, EEG Course Director, Mayo Clinic, Rochester, Minn 55901.

AMERICAN RHEUMATISM ASSOCIATION ANNUAL MEETING

June 15, 16

New York Hilton Hotel, New York City

For information, write: Miss Margaret M. Walsh, executive secretary, ARA, Section of the Arthritis Foundation, 1212 Avenue of the Americas, New York, NY 10036.

NINTH ANNUAL MEETING AMERICAN ASSOCIATION FOR THE STUDY OF HEADACHE

June 17

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For information, write: Seymour Diamond, MD, 5214 North Western Ave, Chicago, Ill 60625.

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May 8-12

CLINICAL AUSCULTATION OF THE HEART

Georgetown University School of Medicine and Georgetown University Hospital, Washington, DC; W. Proctor Harvey, MD, FACP director.

May 15-19

RECENT ADVANCES IN CLINICAL ENDOCRINOLOGY

University of Washington, Seattle, Wash; Robert H. Williams, MD, FACP, director; Neil J. Elgee, MD, FACP, and Francis C. Wood, Jr., MD, co-directors.

May 22-26

CLINICAL APPLICATIONS AND RECENT ADVANCES IN ELECTROPHYSIOLOGY OF THE HEART

New York University School of Medicine, and Medical Center, New York, NY; Charles E. Kossmann, MD, FACP, director; Jacob I. Hirsch, MD, FACP, co-director.

June 12-16

INTERNAL MEDICINE: CURRENT PHYSIOLOGICAL CONCEPTS IN DIAGNOSIS AND TREATMENT

University of Cincinnati College of Medicine, Cincinnati, Ohio; Richard W. Vilter, MD, FACP, director.

June 19-21

CLINICAL APPLICATIONS—RECENT ADVANCES IN PHARMACOLOGY

University of Iowa, Iowa City, Iowa; William B. Bean, MD, FACP, director.



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EXECUTIVE SECRETARY'S NEWSLETTER

March, 1967

ANNUAL MEETING

The Faculty's Annual Meeting is scheduled for:

WEDNESDAY, THURSDAY, AND FRIDAY, APRIL 19, 20 and 21

The House of Delegates' sessions are on:

Wednesday, 9:30 a.m., The Alcazar

Friday, 2:00 p.m., Faculty Building

The Annual Presidential Dinner is scheduled for:

Thursday, 6:30 p.m., The Sheraton-Belvedere Hotel

Hotel reservations may be made at the Belvedere from the block of 50 rooms set aside for the Faculty's use. Reservation blank in this issue of the Journal.

REFERENCE COMMITTEE MEETING

Reference Committee meeting is set for Wednesday, March 29, at 8:00 p.m., in the Faculty Building.

Five resolutions are to be considered that night and recommendations developed for presentation to the House of Delegates on Friday, April 21, at 2:00 p.m.

GENERAL MEETING

The General Meeting for election of two members of the Board of Medical Examiners will be held on Thursday, April 20, at 12 Noon at the Alcazar.

A complete list of nominations is available to members through the Faculty office.

NOTICE

The newly formed Maryland Urological Society will meet on April 19, at 5 p.m. at the University Club. For further information, call Dr. John Hogan, 685-8676.

NEWS NOTES

Harry M. Robinson, Jr., M.D., Baltimore, has been reappointed a member of the Subcommittee on Skin of the AMA's Committee on Rating of Mental and Physical Impairment.

Russell S. Fisher, M.D., Baltimore, has been renamed to the Chairmanship of the Committee on Medicolegal Problems of the AMA.

Paul J. Schmidt, M.D., Bethesda, has been reappointed a consultant to the Committee on Blood of the AMA.

Abraham J. Mirkin, M.D., Cumberland, has been redesignated as a member of the Committee on Medical Aspects of Automotive Safety of the AMA.

John J. Curry, M.D., Silver Spring, has been reappointed to membership on the AMA's Council on Drugs.

RADIOLOGY FELLOW

Donald A. Wolfel, M.D., Baltimore, was inducted as a Fellow of the American College of Radiology, in Chicago.

ANESTHESIA FELLOWS

New Fellows of the American College of Anesthesiology are: Edwin J. Goldman, M.D., Baltimore; and Carl A. Meyer, Jr., M.D., Silver Spring.

ELECTION

William Carl Ebeling, M.D., was elected President of the Medical and Dental Staff of Bon Secours Hospital at the recent meeting of that group.

STROKE PROGRAM OFFICE

The Heart Association of Maryland has established a Stroke Program office to develop needed information services and demonstration programs for physicians and their patients. It will also establish a Strokes registry to provide Maryland with a central source of information concerning the number of patients, their needs, and what happens to them.

John W. Sargeant

Executive Secretary

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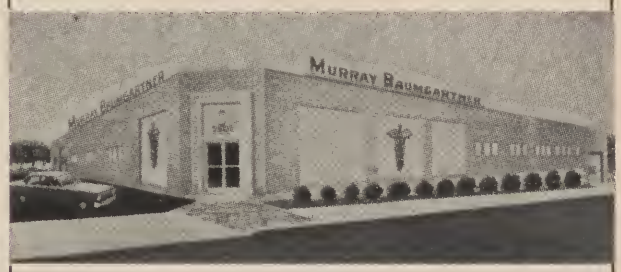
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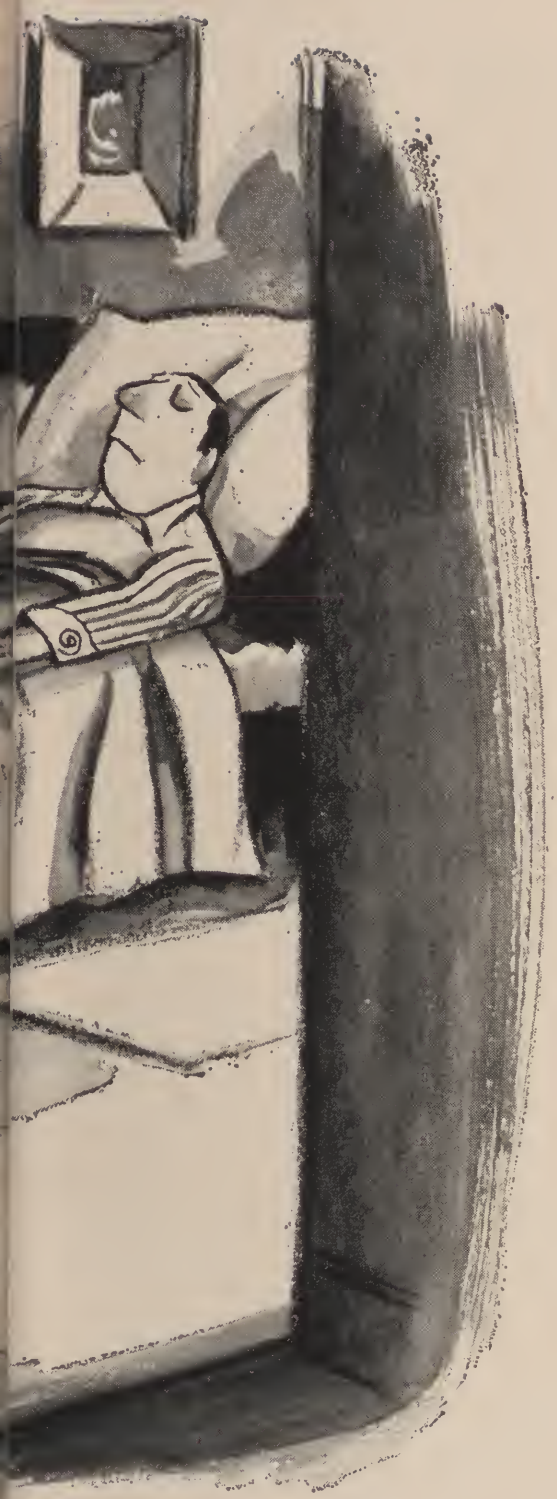
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Drug addiction withdrawal symptoms	●		●
Emotional disturbances (moderate to severe)	●		
Nausea & vomiting	●		●
Neurological disorders	●		
Obstetrics	●	●	●
Pain	●	●	●
Pediatrics	●	●	●
Porphyria	●	●	
Psychiatric disorders	●		
Hiccups—refractory	●		
Senile agitation	●		
Surgery	●	●	●
Tetanus	●	●	

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For a comprehensive presentation of 'Thorazine' prescribing information and side effects reported with phenothiazine derivatives, please refer to SK&F literature or *PDR*.

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From Washington

The Johnson administration's health legislation program this year includes proposals to expand medicare and limit medicaid, and more money is being requested for most federal activities in the health field.

President Johnson also has asked Congress for anti-air pollution legislation and stricter anti-water measures.

The President termed medicare "an unqualified success," but added "there are improvements which can be made and shortcomings which need prompt attention." He proposed that the 1.5 million disabled persons receiving other Social Security and railroad retirement benefits also be included under medicare. He said "certain types of podiatry" should be included in medicare benefits. He further directed the Secretary of Health, Education, and Welfare "to undertake immediately a comprehensive study of the problems of including drugs under medicare."

Johnson noted that only 415,000, less than half of the 850,000 total, of nursing home beds in the nation met federal standards and that only 3,000 of the total of 20,000 nursing homes had qualified under medicare. To move toward correcting this situation, he wants more money for more health facilities and better health care institutions for the aged.

The President called for extension of existing legislation to improve state and local health planning for the elderly and to launch special pilot projects to bring comprehensive medical and rehabilitation services to the aged.

As for limiting medicaid (Title XIX of Social Security), Johnson said that a state should not be permitted to have its income ceilings for medical assistance more than 50% higher than the level set for welfare assistance. The medicaid program, which now gives states carte blanche as to income standards, became the subject of widespread controversy after New York set an eligibility standard of $6,000 net income for a family of four.

Twenty-eight states and jurisdictions had medicaid programs by Jan 1, 1967, and it is estimated that 30 will have them by July 1, 1967, and 48 by July, 1968. Title XIX programs replace the medical vendor payment part of existing federal-state welfare programs, including Kerr-Mills.

The administration's fiscal 1968 budget calls for general fund expenditures of $11.7 billion for carrying out existing and proposed new programs of the Department of Health, Education, and Welfare (HEW). This is an increase of $1 billion over current year spending. In addition to the general fund outlays on behalf of HEW, the budget forecasts benefit payment and administrative expenditures in 1968 from Social Security trust funds in the amount of $31 billion, an increase of $5.5 billion over 1967.

Health program highlights of the HEW budget include a 5% increase, to $1.45 billion, for medical research, and a 6% increase, to $68 million, for the Food and Drug Administration (FDA). The $4 million increase in the FDA budget will be used to: (1) expedite the review and surveillance of new drugs for safety and efficacy, (2) expand extramural research into the side effects of oral contraceptives, (3) expand the program established under last year's Drug Abuse Control Amendments, and (4) carry out the new Fair Packaging and Labelling Act. The 1968 budget will also emphasize regulation of barbiturates, amphetamines, and other drugs affecting the central nervous system, and a step-up in FDA's food standards program.

The budget for Regional Medical Programs is $16 million.

It is expected that grants will be awarded to regional groups in 1968 primarily to support a rapid expansion throughout the nation of operational activities begun during 1967, and an expansion and supplementation of planning activities begun in 1966. Emphasis will be on regional planning and coordination of medical resources, continuing education for doctors and other medi-

---

A monthly summary of Washington news prepared in the Washington, DC, office of the American Medical Association.



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cal personnel, and the rapid distribution of new knowledge and techniques.

The total Children's Bureau budget request for fiscal year 1968 is almost $246 million, an increase of about 5%, or about $11 million, over 1967. The largest share of the approximately $11 million increase is $5 million additional for special project grants for health of school and pre-school children.

* * * * *

New clinical studies are being permitted with DMSO (dimethyl sulfoxide) under guidelines established to provide the maximum protection possible for patients receiving the drug.

James L. Goddard, MD, Commissioner of Food and Drugs, said: "A comprehensive evaluation of all data available to us on DMSO has been completed. Indications that the drug may be of value in treating certain conditions justify further clinical investigations."

He warned, however, that these trials must be carefully planned and controlled.

"Serious toxic signs are observed in animals used in DMSO experiments," Dr. Goddard said. "Since these effects vary considerably among different species, it is possible that the drug could be less toxic in humans. But this cannot be taken for granted."

Occurrences of eye changes in DMSO-treated animals led the Food and Drug Administration to suspend clinical trials with the drug a year ago.

* * * * *

The Army and Navy will draft 2,118 medical doctors and 111 osteopaths starting in July.

The Defense Department said Selective Service was requested to provide the doctors because an insufficient number had volunteered to be able to replace men leaving service after two years' active duty. The Air Force is meeting its need and will not participate in the summer draft call. Of the 2,229 doctors to be drafted, 1,537 will go on duty in the Army and 692 in the Navy.

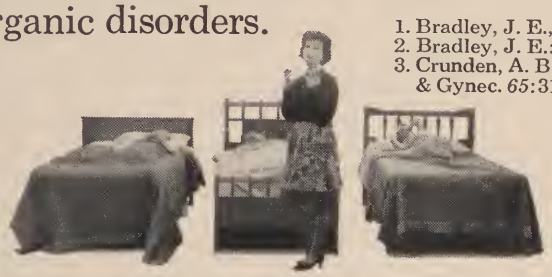
Last April, the Armed Forces issued new regulations under which doctors of osteopathy who volunteered for service could be commissioned. The Pentagon said fewer than a dozen had volunteered, however.



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1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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From Dallas

Four of the world's leading medical authorities on obesity met in a seminar on February 6 to discuss what a Swiss investigator has termed "an overlooked but immensely serious disease that is more common than the cold and perhaps a far greater contributor to man's unhappiness and loss of life than even cancer."

This statement, quoted by Jean Mayer, MD, director of the Department of Nutrition at Harvard University's School of Public Health, marked the opening of the Strasenburgh Obesity Seminar in Dallas.

Dr. Mayer holds a PhD in physiological chemistry from Yale University and a doctor of science degree from Sorbonne University. He had previously been affiliated with the United Nation's Food and Agriculture Organization.

In his discussion, Dr. Mayer placed particular emphasis on the physiology of obesity and the sensation of hunger. He said, "Among obese subjects, abnormalities in satiety or satisfaction may be much more common than abnormalities in hunger.

"Despite folklore to the contrary, research seems to indicate that obese subjects miss breakfast, lunch or dinner *more* frequently than the non-obese; they eat sweet desserts *less* often; but they *more* often clear their plates and tend to eat *more* snacks in the absence of hunger sensations.

"However," Dr. Mayer cautioned, "it is at the end of meals that obese subjects differ most from non-obese. They require more will-power to stop eating, even though they report more frequent sensations of discomfort at the end of meals. The obese are frequently preoccupied with thoughts of food *after* a meal, a phenomenon which is rarely found in the non-obese."

Among the other participants in the seminar was Burton Cohen, MD, senior attending cardiologist at St. Elizabeth's Hospital in Elizabeth, NJ, and assistant professor of clinical medicine at New Jersey College of Medicine and Dentistry in Jersey City. Dr. Cohen is also associate director of the White Cardiopulmonary Institute, Pollak Chest Hospital, Jersey City.

Dr. Cohen discussed the treatment of obesity as a medical disease in office practice. He noted that of 300 consecutive patient physical examinations

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over an eight-month period, nearly half (48.3%) were classified as obese (more than 15% above standard weight).

Among this obese group, 12.3% had high blood pressure; 10.3% showed an elevated blood cholesterol level; 9% had a history of gall bladder disease; 7.7% were diabetic; and 6.7% gave evidence of heart damage from arterial blockage.

Dr. Cohen indicated the use of prolonged release anoretic (appetite-suppressant) agents as part of a comprehensive supervised program of weight reduction "can produce very satisfactory results."

"Over an average of 6.5 months, 35 obese patients suffering from high blood pressure reduced their average body weight from 204.6 pounds to 171.8 pounds. Average blood pressures for this group dropped from 189.0/105.0 to 138.4/83.3.

"Similarly, in the management of 19 patients with diabetes mellitus, an average weight reduction for the group to 170.9 pounds from 180.8 pounds allowed the average insulin requirement to be nearly halved from an average of 37.0 units to 19.2 units."

Edgar Stillwell Gordon, MD, joined the discussion to describe the relationship between metabolism and obesity. Dr. Gordon, a graduate of the Harvard University School of Medicine and formerly a resident in pathology at Massachusetts General Hospital, Boston, is now professor of medicine and chief of the division of metabolism and endocrinology at University Hospital, Madison, Wisc.

"Obesity may be related to individual differences in the thermodynamic efficiency of the 'human engine' from person to person," Dr. Gordon said. "If the 'human engine' is even one or two percent inefficient, a person can become obese.

"There seems to be a progressive loss of ability to oxidize or 'burn' glucose sugars from the normal individual to the mildly obese to the diabetic obese, and a similar pattern seems to take place in the oxidation of free fatty acids."

Dr. Gordon stressed that there are "many oddities of metabolic behavior in the obese, and we're not sure if these differences between normal and obese patients are the result or the cause of the obesity."

"I still think," Dr. Gordon concluded, "that people are obese because they eat too much, but

what is too much for one man is not too much for another."

The fourth participant in the seminar was Alvan Richard Feinstein, MD, presently associate professor of medicine at Yale University. Dr. Feinstein received his medical degree from the University of Chicago in 1952 and since that time has served as a visiting investigator at the Rockefeller Institute Hospital and as assistant resident in medicine at Presbyterian Hospital, New York City. Dr. Feinstein was previously director of epidemiologic studies at Irvington House in New York City and chief of clinical biostatistics at the Veterans' Hospital in New Haven, Conn.

"The fact of obesity is of direct relevance in the presence and treatment of such conditions as diabetes, cardiovascular conditions and orthopedic ailments," Dr. Feinstein said. "In the past," he continued, "we have probably placed too little emphasis on the importance of the so-called 'Pickwickian syndrome' in which obesity causes a lessening of vital lung capacity and the characteristic 'fat boy' appearance and wheeze. This, in turn, seriously hampers oxygen exchange and can badly upset the body's whole system of cell metabolism."

New release from Strasenburgh Laboratories, Feb 7, 1967.

From Cartagena

The S.S. HOPE arrived in the port city of Cartagena, Colombia, on February 16, with 104 doctors, nurses and technologists aboard, to begin a 10-month medical teaching-treatment mission.

Heading the HOPE team is William B. Walsh, MD, of Washington, DC, president and founder of Project HOPE. Walter C. Rogers, MD, of Pasadena, Cal, who served with HOPE in Africa, and as chief of staff aboard the ship last year in Nicaragua, is aboard again this year in that capacity. William W. Peters, of Greensburg, Pa, is hospital administrator and Dorothy Aeschliman, of Sacramento, Cal, is chief nurse. Miss Aeschliman has served on each of HOPE's voyages with the exception of last year's mission to Nicaragua. Captain Elijah Howe, of Middletown, New York, a veteran of HOPE's voyages to Peru and Nicaragua, heads the Grace Line crew which operates the ship.

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HOME OFFICE — BOSTON, MASS.

mented by groups of 30 volunteer physicians and dentists who serve as volunteers on a rotating basis for periods of two months each. Together, the permanent staff and volunteers work side-by-side with their Colombia counterparts in wards, laboratories, classrooms, and in cities and towns surrounding Cartagena.

The mission to Colombia marks the third visit of the S.S. HOPE to South America. In 1962-63, the medical programs were conducted in Peru and in 1964, Ecuador. Other nations visited since its maiden voyage in 1960 include Indonesia, South Vietnam, Guinea and Nicaragua. HOPE shore-based centers remain in Vietnam, Peru, Ecuador and Nicaragua.

HOPE is in Colombia at the invitation of the Colombia Medical School Association and the University of Cartagena School of Medicine, in cooperation with the government of Colombia. HOPE will offer training programs in medicine, dentistry, nursing, medical technology and public health.

Founded in 1958 by Dr. Walsh, Project HOPE is the principal activity of The People-to-People Health Foundation, Inc., of Washington, DC, an independent, non-profit corporation sponsored by contributions from the American people. American industry alone has donated nearly $9 million in products.

From a Project HOPE news release, Feb 1967.

From New York

Fewer new medicines were introduced in the United States in 1966 than in any of the previous 18 years for which accurate records are available, according to a report released January 30 by Paul de Haen, Inc., Drug Information Services.

The number of prescription drug products introduced last year dropped to 80 from 112 the year before. Over a ten-year period the number of new medicines approved by the United States Food and Drug Administration for marketing has declined 80%, the report stated. New drug products consist of single chemical agents, duplicates of existing products, combinations of existing products and new dosage forms.

Sharpest decline was in the number of single new chemical agents. The figure reached a new low of 12 after a high of 63 in 1959.

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Eutaw Savings Bank

EUTAW AND FAYETTE STREETS

6 CONVENIENT OFFICES

ASSETS .....Over $115,000,000

Member Federal Deposit Insurance Corporation

MAXIMUM INSURANCE FOR EACH DEPOSITOR $15,000

in each separate right or capacity

PHARMACEUTICAL SPECIALTIES INTRODUCED IN THE UNITED STATES
1957 - 1966

Year	Number of Drug Firms	Total New Products	New Single Chemicals	Duplicate Single Products	Combination Products
1957	127	400	51	88	261
1958	126	370	44	73	253
1959	107	315	63	49	203
1960	109	306	45	62	199
1961	111	260	39	32	189
1962	108	250	27	43	180
1963	89	199	16	34	149
1964	82	157	17	29	111
1965	65	112	23	18	71
1966	52	80	12	15	53
Total		2,449	337	443	1,669

New Single Chemicals: products which are new single chemical agents not previously known, including new salts.

Duplicate Single Products: products such as meprobamate which are put out by various manufacturers.

Combination Products: products having more than one active ingredient.

The Original

GOLDEN CARE

REGISTERED UNITED STATES PATENT OFFICE NO. 818272

WORLD'S FINEST MATTRESS

Made under and contains United States Patent No. 2,513,582

ADJUSTS TO YOUR BODY FOR LEVEL POSTURE,
PERFECT COMFORT AND HEALTHFUL SLEEP



RIGHT WAY **WRONG WAY**

YOUR BED WILL BE MEASURED TO THE EXACT INCH, CHOICE OF FIRMNESS, CUSTOM MADE WHEN NECESSARY, IN BEAUTIFUL FABRIC FOR CONVERTIBLES, HOSPITAL AND REGULAR BEDS, IN ALL SIZES.

Mattress and Box Spring, $310.00

CUSTOM SLEEP SHOPPES, INC.
7234 Haverford Avenue
PHILADELPHIA, PENNSYLVANIA
GR 7-4637

CUSTOM SLEEP SHOPPES OF MARYLAND, INC.
417 E. 33rd Street
BALTIMORE, MARYLAND
243-5054

CUSTOM SLEEP SHOPPES, LTD.
7910 Georgia Avenue
SILVER SPRING, MARYLAND
587-1131

The seven drug products are: a highly potent diuretic, an antituberculosis agent, two tranquilizers, an antidepressant, an antiarthritic and a drug for anemia.

The number of firms introducing new drug products has also declined sharply, the report indicates, from 127 firms in 1957 to 52 in 1966.

Commenting on the figures for 1966 Mr. de Haen said they show a continuation of trends that have important implications for the American public. He identified them as follows:

1. The decline in introductions of major new prescription drugs in the United States.
2. The increased time required by the Food and Drug Administration to act on approval of new drugs.
3. The increasing number of new drugs being marketed overseas before they are available to physicians in this country.
4. The decline in the number of American companies that are introducing new medicines. (Since the cost of pharmaceutical research is increasing—because of government regulations and because today's highly potent and effective drugs require more extensive studies prior to general release to the practicing physician—it is expected that drug research and development in the United States will eventually be conducted by fewer companies. However, the limited information from the Federal Drug Administration regarding the number of new drugs submitted each year for approval will make it difficult to assess the course of this latter trend.)

The Table shows the results of a de Haen New Product Survey covering the past ten years.

The number of single chemical agents introduced in the United States last year was lower than in any of the four major countries of western Europe. Thirty-four were marketed in France, 42 in Germany, 20 in Great Britain and 21 in Italy. One-third of all these drugs were developed by American scientists. During 1966 the American drug industry marketed in those countries seven new single chemical agents that were not available to physicians in the United States during the year. Two of the seven, however, were approved for marketing in this country in January 1967.

MAKE YOUR HOTEL ROOM RESERVATIONS *NOW*

for the

ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY

APRIL 19, 20, 21, 1967

A block of rooms has been set aside at the SHERATON-BELVEDERE HOTEL, Baltimore, for those attending this meeting. Because of many activities in the city, rooms will be at a premium.

The rates will be from $17.00 to $19.00 for a twin bedded room and bath for two persons; single occupancy will be $13.00 to $15.00.

FOR YOUR HOTEL RESERVATION DETACH AND MAIL THIS SLIP DIRECTLY TO:

Mrs. Jacqueline Amati
SHERATON-BELVEDERE HOTEL
Charles & Chase Sts., Balto., Md. 21202

Name _____

Address _____ **City** _____ **State** _____

Please reserve ..... **rooms Approximate rate** .....**No. of persons**.....

Date of arrival.....**Date of departure** .....

Attending Annual Meeting of the Medical and Chirurgical Faculty.
All requests subject to confirmation.

FOUR OF THE PROMINENT PHYSICIANS WHO WILL SPEAK AT APRIL MEETING



Dr. Carbone

CURRENT MANAGEMENT OF PATIENTS WITH MALIGNANT LYMPHOMA
The Annual I. Ridgeway Trimble Lecture
presented by
PAUL P. CARBONE, MD

Dr. Carbone is head of the Solid Tumor Service Medicine Branch at the National Cancer Institute in Bethesda.

After an internship and two years as medical resident, Dr. Carbone became senior investigator of the NCI Medicine Branch. Since 1962 he has been clinical instructor in medicine at Georgetown University Medical School and hematology lecturer at the Walter Reed Army Institute of Research. Dr. Carbone is a member of many medical societies, among them the American Federation of Clinical Research, the American Association for Cancer Research, the American Society of Hematology, the Transplantation Society, and the American Society of Clinical Oncology. In 1963 he was certified by the Board of Internal Medicine.

BRONCHOGENIC CARCINOMA
The Annual J. M. T. Finney Fund Lecture
presented by
JOHN Y. TEMPLETON, III, MD



Dr. Templeton

Dr. Templeton is director of the Division of Surgery at the Pennsylvania Hospital and professor of surgery at the University of Pennsylvania School of Medicine.

A graduate of Davidson College in and Jefferson Medical College in Philadelphia, Dr. Templeton served an internship and a residency in general and thoracic surgery at Jefferson Hospital. His many hospital appointments include those of consultant in thoracic surgery at the Philadelphia Naval Hospital, Valley Forge Army Hospital, and the Chestnut Hill Hospital; consultant in cardiovascular surgery at the Polyclinic Hospital in Harrisburg; and consultant in cardiac surgery at Haverford Hospital. Dr. Templeton is a member of numerous medical societies and committees, has many teaching appointments, and is the author of more than sixty scientific articles, which have been published in national and specialty journals.

Dr. Templeton is certified by the American Board of Surgery and by the American Board of Thoracic Surgery.



Dr. Gordon

THE METABOLIC RELATIONSHIPS BETWEEN OBESITY, DIABETES, AND CORONARY ARTERY DISEASE
The Annual Jesse C. Coggins Fund Lecture on Geriatrics
presented by
EDGAR S. GORDON, MD

Dr. Gordon is professor of medicine and chief of the Metabolism and Endocrinology Clinic at the University of Wisconsin.

After graduation from the University of Wisconsin, Dr. Gordon received his MD degree from Harvard Medical School. He is presently consultant to the National Aeronautics and Space Agency, Oak Ridge Institute of Nuclear Studies, and to the Institute of Arthritis and Metabolic Disease of the National Institutes of Health. Dr. Gordon is a Diplomate of the American Board of Internal Medicine, and a member of numerous other professional societies. His special fields of interest are: isotopes, nutrition, endocrinology, adrenal physiology, neuroendocrine system, and metabolism. Dr. Gordon is well-known for his clinical research in obesity.

His lecture will be open to the general public as well as to members of the medical profession.

THE MENOPAUSE
J. Mason Hundley Annual Lecture in Gynecology
presented by
JOHN W. WALSH, MD



Dr. Walsh

Dr. Walsh is clinical professor of obstetrics and gynecology at the Georgetown University School of Medicine.

A graduate of Notre Dame University, he received his MD degree from the Long Island College of Medicine. He served an internship at the Long Island College Hospital and a residency at the New York Lying-In Hospital. During his military service, Dr. Walsh received a Unit Citation and four Battle Stars. He is a member of several medical societies and is a founding fellow of the American College of Obstetrics and Gynecology. He has had numerous articles published on the subjects of x-ray pelvimetry, sarcoma of the uterus, and endometrial carcinoma.

In February of this year, Dr. Walsh began his first voyage with the hospital ship S.S. HOPE, during which he will head a rotating staff of three obstetricians and gynecologists in Cartagena, Colombia, for a period of five weeks. He will return to this country just prior to presenting the Hundley Lecture. Dr. Walsh is a brother of William B. Walsh, MD, founder and president of Project HOPE.

169th ANNUAL MEETING OF THE
WEDNESDAY-FRIDAY, APRIL 19-21,

All Physicians and Paramedical Personnel Are Invited to Attend

HOUSE OF DELEGATES MEETING

Wednesday, April 19, 9:30 AM, The Alcazar

ALL MEMBERS OF THE FACULTY ARE WELCOME

ROUND TABLE LUNCHEON

Wednesday, April 19
12:30 PM

One West Restaurant
Charles Street at Eager

26 different discussions with moderators well versed in the various subjects.
MAKE RESERVATIONS EARLY!

WEDNESDAY, APRIL 19

2:15 PM–PROBLEMS IN CHRONIC HEMODIALYSIS: TECHNICAL AND CLINICAL CONSIDERATIONS
Ervin A. Gombos, MD

3:15 PM–THE ROLE OF THE INTERNIST OR FAMILY PHYSICIAN IN RENAL TRANSPLANTATION
Joseph H. Holmes, MD

8:30 PM–THE METABOLIC RELATIONSHIPS BETWEEN OBESITY, DIABETES, AND CORONARY ARTERY DISEASE
Edgar S. Gordon, MD

THURSDAY, APRIL 20

9:30 AM–DIFFERENTIAL DIAGNOSIS OF HYPERCALCEMIA
W. Lester Henry, Jr., MD

10:15 AM–MEDICAL CARE: THE NEXT DECADE IN THE PUBLIC-PRIVATE PARTNERSHIP
Philip R. Lee, MD

11:30 AM–PARTNERSHIPS IN PEPTIC ULCER
Milford O. Rouse, MD

12:15 PM–ELECTION OF BOARD OF MEDICAL EXAMINERS

2:15 PM–CURRENT MANAGEMENT OF PATIENTS WITH MALIGNANT LYMPHOMA
Paul P. Carbone, MD

3 PM–THE MENOPAUSE
John W. Walsh, MD

4 PM–BRONCHOGENIC CARCINOMA
John Y. Templeton, III, MD

HEALTH EVALUATION TESTS

AVAILABLE TO
MEMBERS OF THE FACULTY
AND THEIR GUESTS

Wednesday, April 19—8:30 AM to 5 PM

Thursday, April 20—8:30 A.M. to 5 PM

Friday, April 21—8:30 AM to 12 Noon

The Alcazar

MEDICAL AND CHIRURGICAL FACULTY AT THE ALCAZAR, BALTIMORE

A Program of Scientific Sessions Designed to Present Recent Developments in a Variety of Medical and Surgical Fields

PRESIDENTIAL DINNER AND RECEPTION

Thursday, April 20
6:15 PM

SHERATON-BELVEDERE HOTEL

PROFESSIONAL ENTERTAINMENT

Eddie Morgan
comedian

Dolores Perry
vocalist

DANCING FOR EVERYONE

NO REGISTRATION FEE

SEE THE EXHIBITS
TECHNICAL AND SCIENTIFIC
The Alcazar
APRIL 19, 20, and 21

FRIDAY, APRIL 21

9:30 AM–THE CLINICAL LABORATORY: PAST, PRESENT, AND FUTURE
Richard E. Palmer, MD

10:15 AM–CURRENT CONCEPTS IN CANCER CHEMOTHERAPY
James F. Holland, MD

11:15 AM–ANEURYSMS OF THE AORTA: A 15-YEAR SURGICAL EXPERIENCE
Michael E. De Bakey, MD

12:30 PM–POPULATION CONTROL
Hugh J. Davis, MD

HOUSE OF DELEGATES
MEETING

Friday, April 21, 2 PM, Faculty Building
ALL MEMBERS OF THE FACULTY
ARE WELCOME

DETAILED PROGRAMS
WILL BE MAILED
TO ALL FACULTY MEMBERS
(To others upon request)

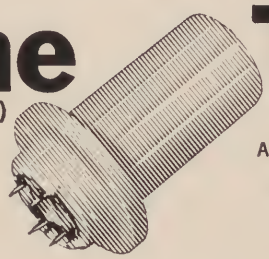
what time is it?

For the past
two years
there's been
one new case
of active tuberculosis
reported for every
four thousand
of U.S. population.

it's time to tine.

Tuberculin, Tine Test

(Rosenthal)



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Order now
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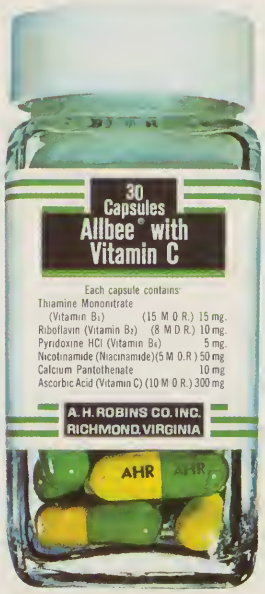
Two ways to give your patients a month's therapeutic supply of vitamin C:



118 grapefruit or 30 Allbee® with C

Your patient would have to eat 118 medium-sized grapefruit (almost 4 a day!) to get as much vitamin C as is provided in just one bottle of 30 Allbee with C capsules (taken one capsule daily). In addition, each capsule supplies full therapeutic amounts of the B-complex vitamins.

Your patients can purchase Allbee with C capsules in the convenient bottle of thirty—a month's supply at a very reasonable price. Also the economy size of 100. Available at pharmacies everywhere on your prescription or recommendation.



A-H-ROBINS

A. H. Robins Company, Richmond, Virginia



the spasm reactors in your practice deserve

"the Donnatal® Effect"

	each tablet, capsule or 5 cc of elixir (23% alcohol)	each Extentab®
hyoscyamine sulfate	0.1037 mg.	0.3111 mg.
atropine sulfate	0.0194 mg.	0.0582 mg.
hysocine hydrobromide	0.0065 mg.	0.0195 mg.
phenobarbital	(¼ gr.) 16.2 mg.	(¾ gr.) 48.6 mg.

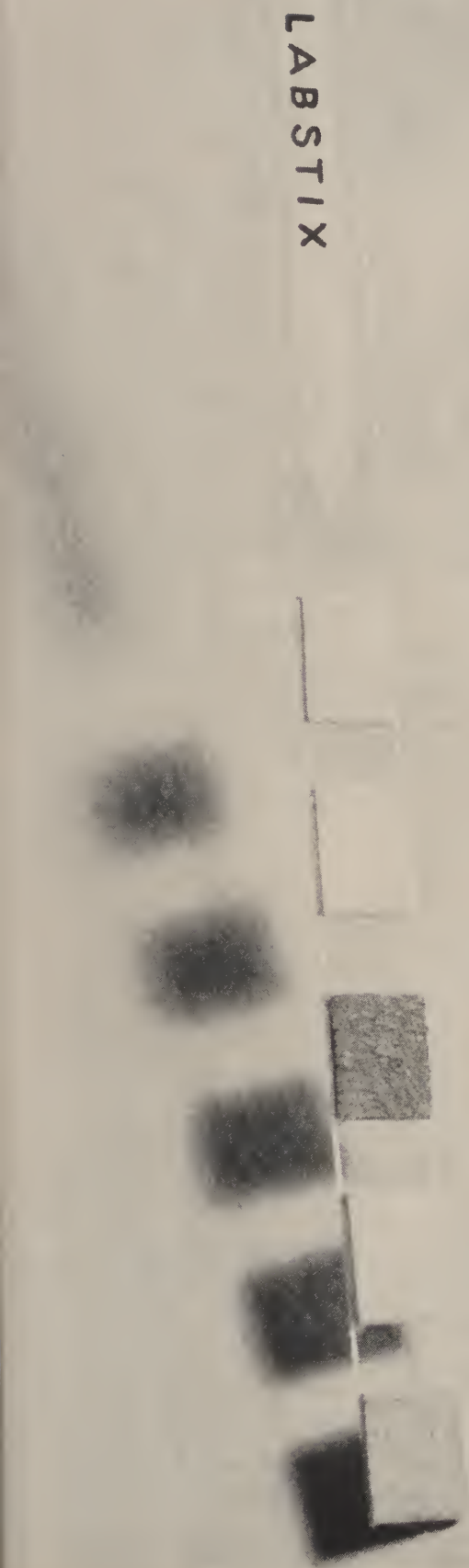
(Warning: may be habit forming)

Brief summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.

A. H. ROBINS COMPANY, RICHMOND, VIRGINIA 23220

A·H·ROBINS

new from Ames
5 basic uro-analytical facts in 30 seconds



Labstix®

BRAND REAGENT STRIPS

...broadest urine screening possible from a single reagent strip

Urine test results with LABSTIX Reagent Strips can represent significant guides to differential diagnosis or therapy in many conditions. An unexpected "positive" may enable you to detect hidden pathology—long before more recognizable symptoms become evident. Negative results, which permit you to rule out abnormalities in a broad clinical range, can serve as baseline values for reference in future examinations. The 5 colorimetric test areas encompassed on LABSTIX Reagent Strips are:

pH—values are read numerically in the essential range of pH 5 to pH 9.

Protein—results are read either in the "plus" system or in mg. % in amounts approximating "trace," 30, 100, 300, and over 1000 mg. %.

Glucose—provides a "Yes-or-No" answer for urine "sugar spill."

Ketones—detects ketone bodies in urine—**both** acetoacetic acid and acetone. Reacts with as little as 5 to 10 mg. % of acetoacetic acid.

Occult Blood—specific test for intact red cells, hemoglobin or myoglobin. Results are read as negative, small, moderate or large amounts.

Now a Clear Reagent Strip of Firm Construction

...facilitates handling during testing procedure. Excellent color contrast made possible by the clear plastic strip, together with the clearly defined color charts provided, permits precise, reproducible colorimetric readings in all 5 test areas. A more definitive interpretation of uro-analytical facts is made possible.

Available: LABSTIX Reagent Strips, bottles of 100 (color charts are supplied with each bottle).

Ames Company, Inc., Elkhart, Indiana

AMES

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Doctor's Day—March 30, 1967

Doctor's Day is a special day observed each year to honor the members of the medical profession, both living and dead, who have devoted their lives to the art of healing.

The idea of Doctor's Day originated in Georgia in 1933 and was adopted by the Woman's Auxiliary to the American Medical Association in 1934. Since the analogy of the carnation is closely intertwined with medical science, the red carnation was chosen in 1949 as the symbol of Doctor's Day.

March 30, the official date, commemorates one of the greatest discoveries for the alleviation of pain and suffering. On March 30, 1842, Dr. Crawford W. Long first used ether anesthesia in surgery.

In recognition of the doctors' contributions to the people and communities they serve, the Enoch Pratt Free Library will dedicate a window of the Central Library to Doctors' Day. The window display will be on view from March 28 to April 24.

Also in honor of Doctor's Day, a contribution will be made by our auxiliary to the American Medical Association Education and Research Foundation, to be divided equally between The Johns Hopkins and The University of Maryland schools of medicine.

Mrs. Percy H. Sutley, *President*
Woman's Auxiliary to the Baltimore City Medical Society

Mrs. William J. R. Dunseath, *Chairman*
Doctor's Day

Your MEDICAL FACULTY at Work

JOHN SARGEANT — EXECUTIVE SECRETARY

EXECUTIVE COMMITTEE, FEBRUARY 2

1. On recommendation of the Public Relations Committee, quarterly meetings of the executive secretaries of component societies, which have been held on a one-year trial basis, were approved on a permanent basis, with the Faculty underwriting the expenses.

2. The Committee approved in principle the suggestion of the University of Maryland Chapter of the Student AMA that representatives of their group attend various Faculty Committee meetings in order to become aware of Faculty activities and to communicate information about them to fellow members. It is to be understood that the Chapter will advise the Faculty in writing as to which Committee meetings they are interested in attending and that, in each case, the Committee chairman will be the final arbiter of attendance.

3. It was reported that a letter from the Judicial Council of the AMA, on the subject of compulsory assessment of staff members at St. Joseph Hospital and Maryland General Hospital, stated, ". . . that compulsory assessments, that is, assessments which, if not paid, would result in the loss of staff privileges, are not considered proper." The Committee agreed that, inasmuch as the complaints involved do not fall within the definition, there has been no violation of ethical principles in this area.

4. A letter from John C. Harvey, MD, written in response to an inquiry from the Committee, was read. The letter stated that staff appointments at the new Good Samaritan Hospital would be made according to the guidelines of the Joint Committee on Accreditation of Hospitals.

5. The Committee voted for the expenditure of up to $15,000 from the Educational Fund for educational and publicity materials necessary in the promotion of the statewide measles immunization program endorsed by the Council on January 19. Plans for the use of these funds, which is limited to the purposes stated, are to be submitted for Committee approval by the steering committee that will be appointed from among Faculty members and State Health Department personnel. Any overage at the conclusion of the campaign, which is essentially a component society project, will be retained by the Faculty in a special account for future immunization programs of like nature.

6. Representatives of the State Health Department, the State Board of Health and Mental Hygiene, the State Budget Bureau, the Faculty Fee Schedule Committee and the Faculty PL 89-97 Subcommittee joined the Executive Committee for an extensive discussion of problems related to the presentation to the State Legislature of the 1968 Fiscal Budget for the State Health Department, particularly as it is affected by the Title 19 program. Mr. Henry Bosz, of the Budget Bureau, reported that the figures for "physicians' services" presented to the Bureau by the Health Department had been in line with the recommendations of the Council on Medical Care, the State Board of Health and Mental Hygiene and the Faculty, but, of necessity, had been cut by the Bureau.

7. The Faculty has made available its services for arbitration of the dispute between four physician-members and Suburban General Hospital with regard to the renewal of a contract covering "Emergency Room Services" on a 24-hour, 365-day basis.

TECHNICAL EXHIBITORS AT THE MED-CHI MEETING APRIL 19, 20, 21

Abbott Laboratories
Aloe Medical-Division of Brunswick Corp.
Baker, Watts & Co.
Baltimore Dictating Machine Company
Carnation Company
Ciba Pharmaceutical Company
Community Health Facilities, Inc.
Consolidated Medical & Dental Services, Inc.
Herbert Cox, Correct Shoes
Dome Laboratories
Edison Voicewriter, Thos. A. Edison Industries
Encyclopaedia Britannica
Endo Laboratories, Inc.
Federated Business Services, Inc.
Flint Laboratories
Geigy Pharmaceuticals
Graymar Company
Hummel-Rhode & Co.
Jobst Institute, Inc.
Lederle Laboratories
Eli Lilly and Company
Mallinckrodt Pharmaceuticals
Maryland Blue Cross & Blue Shield Plans
Maryland Pharmaceutical Association
Mead Johnson Laboratories
Med-Chi Insurance Trust
Medco Products Co., Inc.—Alan G. Day
Mercantile-Safe Deposit and Trust Company
Merck Sharp & Dohme
C. V. Mosby Company
Murray-Baumgartner Surgical Instrument Co., Inc.
Organon Inc.
Pfizer Laboratories
Wm. P. Poythress & Co., Inc.
A. H. Robins Company, Inc.
Roche Laboratories
William H. Rorer, Inc.
Sanborn Company
Sandoz Pharmaceuticals
W. B. Saunders Company
G. D. Searle & Co.
Skill Surgical, Inc.
Smith, Miller & Patch, Inc.
Squibb, Inc.
The Stuart Company
Syntex Laboratories, Inc.
U. S. Vitamin & Pharmaceutical Corp.
The Upjohn Company
Voca of Maryland, Division of Smith Communications, Inc.
The William A. Webster Company
Wyeth Laboratories

Smith Kline & French Laboratories and Hynson, Westcott & Dunning, Inc., are making a contribution, although they are unable to have exhibits this year.

Tandearil®
oxyphenbutazone

Therapeutic Effects: Tandearil is a nonhormonal compound which may rapidly resolve inflammation and help restore normal joint function. Its action does not affect pituitary-adrenal function or impair immune responses. Its value in osteoarthritis is especially noteworthy because this disorder responds inconsistently to steroids and is often resistant to salicylates. Further, indomethacin is limited only to osteoarthritis of the hip, whereas oxyphenbutazone is effective in all forms of the disease.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: The initial daily dosage in adults is 300-600 mg. in divided daily doses. When improvement occurs, dosage should be decreased to the minimum effective level; this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

For complete details, please refer to full prescribing information. 6562-VI(B)R

Availability: Tablets of 100 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

Geigy

Tandearil®
oxyphenbutazone

helps osteoarthritic joints move again

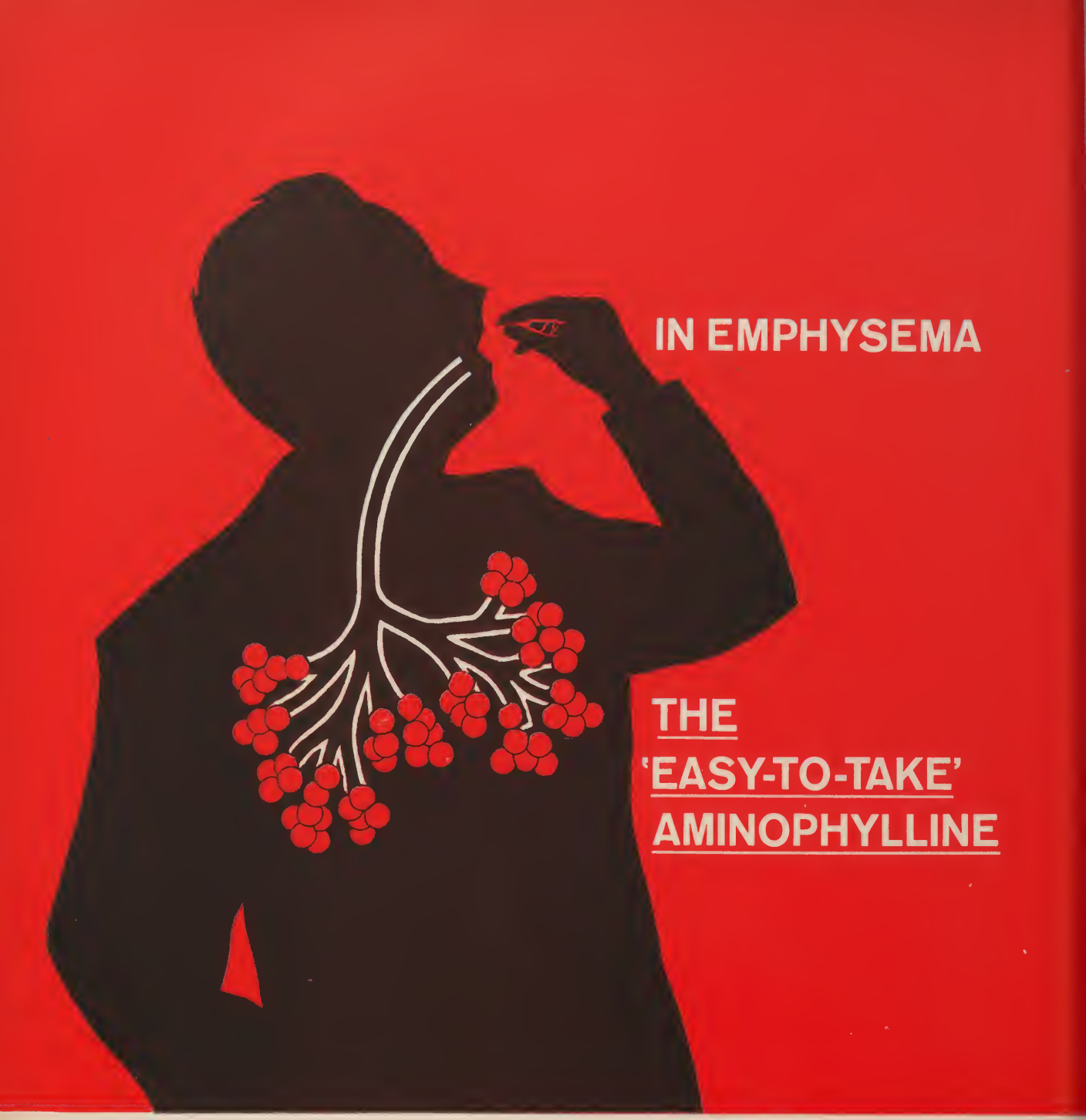


3 out of 4 osteoarthritics completely or markedly improved

Sperling, I.L.: 3 Years' Experience with Oxyphenbutazone in the Treatment of Rheumatic Disorders, Applied Therapeutics 6:117, 1964.	76.9% of 407 patients
Watts, T.W., Jr.: Treatment of Rheumatoid Disorders with Oxyphenbutazone, Clin. Med. 73:65, 1966.	84.6% of 39 patients

Please see adjoining page for brief prescribing summary

TA-4919 PC



Aminophylline dura-tabs®

prolonged-medication tablets 4½ gr. (0.3 Gm.)

Precautions: Use with caution in patients with poor renal function as a decreased rate of excretion may lead to accumulation and untoward reactions. Gastric irritation may occasionally be observed in certain patients sensitive to oral aminophylline.

Dosage: Adults, 1 to 2 Aminophylline Dura-Tabs each 8 or 12 hours, with food.

RARELY UPSET THE STOMACH

Oral aminophylline needn't disturb the stomach—nor a good night's sleep. Patients breathe easier all day, sleep better all night, as each Aminophylline Dura-Tab dose provides effective therapeutic activity for up to 12 hours. And unlike conventional tablets, AMINOPHYLLINE DURA-TABS seldom cause gastric distress. The special Dura-Tab process allows the gradual absorption of the medication from the intestinal tract with only a small fraction of the dose released in the stomach.

ETHICAL GUIDELINES FROM THE AMA JUDICIAL COUNCIL

Clinical Investigation

At the 1966 Annual Convention of its House of Delegates, the American Medical Association endorsed the ethical principles set forth in the 1964 *Declaration of Helsinki* of the World Medical Association concerning human experimentation. These principles conform to and express fundamental concepts already embodied in the *Principles of Medical Ethics* of the American Medical Association.

The following guidelines, enlarging on these fundamental concepts, are intended to aid physicians in fulfilling their ethical responsibilities when they engage in the clinical investigation of new drugs and procedures:

1. A physician may participate in clinical investigation only to the extent that his activities are a part of a systematic program competently designed, under accepted standards of scientific research, to produce data which is scientifically valid and significant.
2. In conducting clinical investigation, the investigator should demonstrate the same concern and caution for the welfare, safety and comfort of the person involved as is required of a physician who is furnishing medical care to a patient independent of any clinical investigation.
3. In clinical investigation *primarily for treatment*—
   a. The physician must recognize that the physician-patient relationship exists and that he is expected to exercise his professional judgment and skill in the best interest of the patient.
   b. Voluntary consent must be obtained from the patient, or from his legally authorized representative if the patient lacks the capacity to consent, following: (a) disclosure that the physician intends to use an investigational drug or experimental procedure, (b) a reasonable explanation of the nature of the drug or procedure to be used, risks to be expected, and possible therapeutic benefits, (c) an offer to answer any inquiries concerning the drug or procedure, and (d) a disclosure of alternative drugs or procedures that may be available.
      i. In exceptional circumstances and to the extent that disclosure of information concerning the nature of the drug or experimental procedure or risks would be expected to materially affect the health of the patient and would be detrimental to his best interests, such information may be withheld from the patient. In such circumstances such information shall be disclosed to a responsible relative or friend of the patient where possible.
      ii. Ordinarily, consent should be in writing, except where the physician deems it necessary to rely upon consent in other than written form because of the physical or emotional state of the patient.
      iii. Where emergency treatment is necessary and the patient is incapable of giving consent and no one is available who has authority to act on his behalf, consent is assumed.
4. In clinical investigation *primarily for the accumulation of scientific knowledge*—
   a. Adequate safeguards must be provided for the welfare, safety and comfort of the subject.
   b. Consent, in writing, should be obtained from the subject, or from his legally authorized representative if the subject lacks the capacity to consent, following: (a) a disclosure of the fact that an investigational drug or procedure is to be used, (b) a reasonable explanation of the nature of the procedure to be used and risks to be expected, and (c) an offer to answer any

inquiries concerning the drug or procedure.

c. Minors or mentally incompetent persons may be used as subjects only if:
   i. The nature of the investigation is such that mentally competent adults would not be suitable subjects.
   ii. Consent, in writing, is given by a legally authorized representative of the subject under circumstances in which an informed and prudent adult would reasonably be expected to volunteer himself or his child as a subject.

d. No person may be used as a subject against his will.

Laboratory Services

The following questions and answers are provided by the Judicial Council in response to inquiries raised by a number of medical societies.

Q: A laboratory is owned by a physician who spends a small portion of his time directing and managing its financial and business affairs. The laboratory work is performed by technicians and directly supervised by a medical technologist with little or no participation by the physician-owner. The physician's name is used in connection with the laboratory in a manner to create the appearance that it is owned, operated and supervised by a doctor of medicine. Is the physician engaged in an unethical activity? Would it make any difference if he were not the owner, but merely received compensation for his time? Or if he were a partner with the supervising technologist or participated without receiving any compensation or share of the profits?

A: In each of the situations set forth above the physician would be guilty of deception and unethical conduct in misrepresenting or aiding the misrepresentation of laboratory services performed and supervised by a non-physician, as physician's services.

Q: A laboratory, owned, operated and supervised by a non-physician in accordance with state law, performs tests exclusively for physicians who receive the results and make their own medical interpretations. Is it permissible for physicians to utilize the services of these laboratories?

A: The physician's ethical responsibility is to provide his patients with high quality services. This includes services which he performs personally and those which he delegates to others. A physician should not utilize the services of any laboratory, irrespective of whether it is operated by a physician or non-physician, unless he has the utmost confidence in the quality of its services. He must always assume personal responsibility for the best interests of his patients. Medical judgment based upon inferior laboratory work is likewise inferior. Medical considerations, not cost, must be paramount when the physician chooses a laboratory. The physician who disregards quality as the primary criterion or who chooses a laboratory because it provides him with low cost laboratory services on which he charges the patient a profit, is derelict in not acting in the best interests of his patient. However, if reliable quality laboratory services are available at lower cost, the *patient* should have the benefit of the savings. As a professional man, the physician is entitled to fair compensation for his services. He is not engaged in a commercial enterprise and he should not make a markup, commission, or profit on the services rendered by others.

Use of Terms "Ethical" and "Unethical"

The Judicial Council has been asked to comment upon the use of the terms "ethical" and "unethical" as used in *Opinions and Reports* of the Judicial Council and resolutions of the House of Delegates of the American Medical Association.

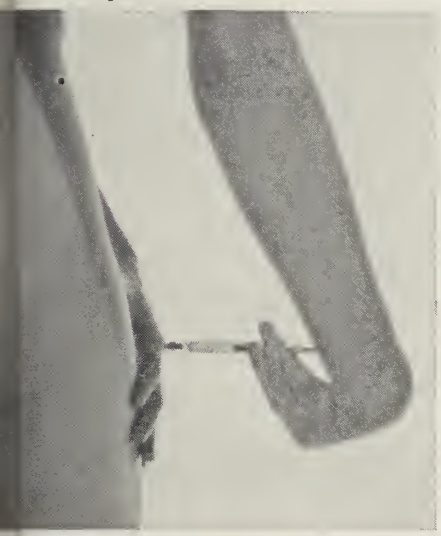
Historically, the term "ethical" has been used in these respects to refer to matters involving (1) moral principles or practices; (2) customs and usages of the medical profession; and (3) matters of policy not necessarily involving issues of morality in the practice of medicine. The term "unethical" has been used to refer to conduct which fails to conform with these professional standards, customs and usages, or policies, as

New
low-cost tetracycline/antifungal therapy

for broad-spectrum activity
plus specific antifungal prophylaxis
at significant patient savings

Whenever tetracycline is indicated in these candidates for Candida:

1. diabetic patients



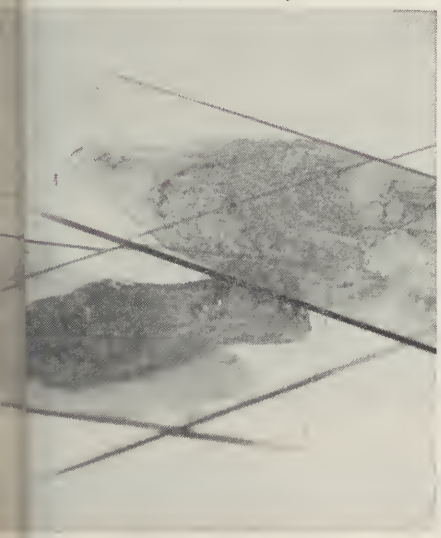
2. nonpregnant women with a history of recent or recurrent monilial vaginitis



3. elderly or debilitated patients



4. patients with a past history of moniliasis



5. patients on long-term tetracycline or corticosteroid therapy



PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indicotions:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Controindications:* The drug is contraindicated in patients hypersensitive to its components. *Wornings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood.) *Precoutions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reoctions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosoge:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

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BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York

Tetrex-F®

Each capsule contains tetracycline phosphate complex equivalent to tetracycline hydrochloride 250 mg. and nystatin 250,000 units.



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Sodium Amobarbital and Sodium Secobarbital

(One-Half Sodium Amobarbital and One-Half Sodium Secobarbital)



Tuinal helps wakeful patients fall asleep fast, stay asleep all night.

Indications: Tuinal, comprised of equal parts of Seconal® Sodium (sodium secobarbital, Lilly) and Amytal® Sodium (sodium amobarbital, Lilly), is indicated for prompt and moderately long-acting hypnosis.

Contraindications: Barbiturates should not be administered to anyone with a history of porphyria, nor should they be given in the presence of uncontrolled pain, because excitement may result.

Warning: May be habit-forming.

Precautions: Tuinal should be used cautiously in patients with decreased liver function, since prolongation of effect may occur.

Adverse Reactions: Idiosyncrasy, such as excitement, hangover, or pain, may appear. Hypersensitivity reactions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.



Dosage: 1½ to 3 grains at bedtime.

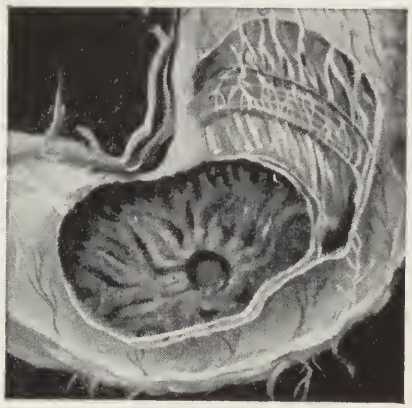
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- In Mylanta, aluminum and magnesium hydroxides are balanced to minimize the chance of constipation or laxation and still achieve rapid acid neutralization and pain relief.
- The positive action of simethicone helps relieve the painful gas symptoms which often accompany the peptic ulcer syndrome.
- The nonfatiguing flavor and smooth, nongritty consistency of tablets and liquid encourage continued patient cooperation during long-term therapy.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) of liquid contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. **Dosage:** one or two tablets, well chewed or allowed to dissolve in the mouth, or one or two teaspoonfuls of liquid to be taken between meals and at bedtime.

The Stuart Company, Pasadena, California
Division of Atlas Chemical Industries, Inc.

Stuart

interpreted by the American Medical Association.

Unethical conduct involving *moral principles,* values and duties calls for disciplinary action such as censure, suspension, or expulsion from medical society membership.

Failure to conform to the *customs and usages* of the medical profession may call for disciplinary action depending upon the particular circumstances involved, local attitudes, and how the conduct in question may reflect upon the dignity of and respect for the medical profession.

In matters strictly of a policy nature, a physician who disagrees with the position of the American Medical Association is entitled to freedom and protection in his point of view.

Charging Penalties for Overdue Accounts

"Since the practice of medicine is a profession and not a business, the practices adopted by businesses are not necessarily suitable for professional practice.

"It is not in the best interest of the public or the profession to charge interest on an unpaid bill or note or to charge a penalty on fees for professional services not paid within a prescribed period of time nor is it proper to charge a patient a flat collection fee if it becomes necessary to refer the account to an agency for collection."

Associations Between Doctors of Medicine and Optometrists

Q: May optometrists be employed as ancillary personnel to assist ophthalmologists?

A: It is not unethical for an ophthalmologist to employ an optometrist as ancillary personnel to assist him provided the optometrist is identified to patients as an optometrist and not as a doctor of medicine. The ophthalmologist has an ethical responsibility to take affirmative measures to make sure that patients will not be given the impression that the optometrist is also a doctor of medicine.

Q: May a physician teach in a school of optometry?

A: Since optometry is not a cult, physicians may, in accord with the provisions of Resolution 107 adopted in June, 1966, by the House of Delegates, teach in recognized schools of optometry for the purpose of improving the quality of optometric education. The scope of this teaching may embrace subjects within the legitimate scope of optometry which are designed to prepare students to engage in optometry within the limits prescribed by law.

Relations with the Communication Media

Many people, literate and well educated, do not possess a special knowledge of medicine. Medical books and journals are not always easily accessible or readily understandable.

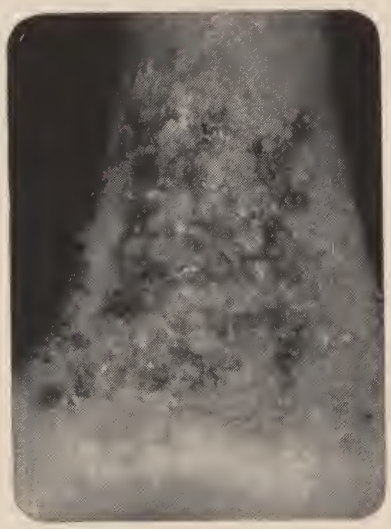
Physicians are aware that patients' information concerning health and health education frequently comes from the daily or weekly newspaper. The press, together with popular magazines, radio, and television, are often the primary, and for many, the only source of information about medicine and health.

The public is eager to learn all it can of the most recent advances in the cure of diseases. It is anxious to learn about and put into effect the best methods of public hygiene and preventive medicine. The daily press and other communication media have correctly considered such subjects as news. It is in the public interest that this news be accurate and presented by spokesmen trained in medicine.

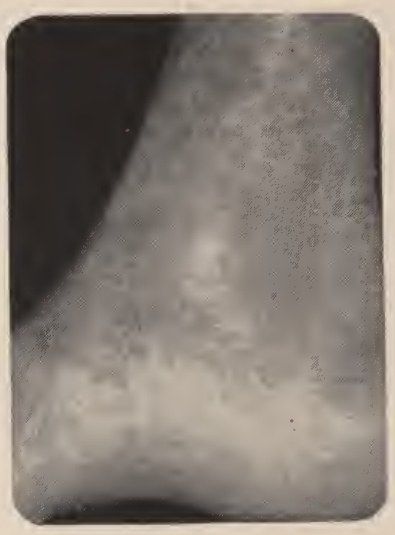
The American Medical Association is well aware that specific decisions regarding relations between physicians and the communication media must and should be determined at the community level by the local medical society and its membership. These guidelines are offered to the county medical society as a starting point and a reference to help them develop and improve press relations at the community level.

The following guidelines have been approved by the Judicial Council of the American Medical Association to aid in the smoother flow of accu-

Eczema of many years... controlled in two weeks



Before treatment



After treatment —
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ARISTOCORT® Triamcinolone Acetonide Topicals have proved exceptionally effective in the control of various forms of eczema: allergic, atopic, nummular, psoriatic, and mycotic.

In most cases responsive to topical ARISTOCORT, the 0.1% concentration is sufficiently potent. The 0.5% concentration provides enhanced topical activity for patients requiring additional potency for proper relief.

Administration and Dosage: Apply sparingly to the affected area 3 or 4 times daily. Some cases of psoriasis may be more effectively treated if the 0.1% Cream or Ointment is applied under an occlusive dressing.

Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

Available in 5 Gm. and 15 Gm. tubes and ½ lb. jars.

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Triamcinolone Acetonide
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rate medical news from the medical profession to those who collect and disseminate such news:

1. Each medical society should appoint a communications committee, or designate a responsible individual or individuals, whose duty shall be to provide the communication media with accurate information on all medical matters of interest to the public. This information should be given freely. The communications committee may also serve in an advisory capacity to all communication media and to all physicians of its society in questions involving relationship with the media. To assist the media in obtaining information, medical societies may furnish the media with a list of names of physicians from whom authoritative information may be obtained, or a designated individual may serve as liaison between the media and the profession and furnish names of physicians to provide authoritative information when required.

   These spokesmen may be quoted by name and title. This should not be considered by their colleagues as seeking publicity, since it is done in the best interest of the public and the profession. They may ethically provide appropriate information regarding medical and public health matters which have been discussed in technical papers or during medical meetings.

   The officers, committee chairmen, and designated spokesmen of medical societies should be available at all times to bonafide representatives of the communication media in order that authentic information may be obtained as soon as possible.

2. Because certain news (1) is a part of the public record, or (2) is a matter of concern to civil authorities, it is readily available for publication. Physicians should cooperate with the press to insure that medical news of this sort is available more promptly and more accurately than would be possible without their assistance.

   News in this category, known as news in the public domain, includes: births, deaths, accidents, and police cases.

   The following information in the public domain can be made available without the patient's consent:

   a. Personal information: patient's name, address, age, sex, race, marital status, employer, occupation, name of parents in case of births, name of next-of-kin in case of deaths.

   b. Nature of accident:
      Only general information regarding injuries will be released. This consists of the name of the injured portion of the body such as back injury, etc.
      It may be stated that there are internal injuries.
      If the patient is unconscious when brought to the hospital, a statement to that effect may be made.
      Statements regarding the circumstances surrounding shootings, knifings and poisonings are properly police matters and questions as to whether they were accidental or otherwise should be referred to the appropriate authorities.
      A statement may be made to the effect that the patient was injured by a knife or other sharp instrument, but no statement may be made as to whether or not it was assault, accident, or self-inflicted.
      A statement may be made that the patient received burns and the member of the body affected may be indicated.
      No statement may be made that there was a suicide or attempted suicide.
      No statement may be made to the effect that intoxication or drug addiction was involved.
      No statement may be made that moral turpitude was involved.

   c. Diagnosis and prognosis:
      Inasmuch as a diagnosis may be made only by a physician and may depend upon X-ray and laboratory studies, no statement regarding diagnosis should be made except by or on behalf of the attending physician
      For the same reason prognosis will be given only by the attending physician or at his direction.

   d. Patient's condition:
      A statement may be made as to the general condition of the patient using the following classifications: minor injuries or





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Side Effects: Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness and CNS depression. Overdosage may result in salicylate intoxication. Meprobamate rarely causes allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. Meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioedema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. A few cases of leukopenia, usually transient, have been reported following prolonged dosage. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

Contraindications: History of sensitivity or severe intolerance to aspirin or meprobamate.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

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similar general diagnosis, good, fair, serious, critical.

3. When information concerning a specific patient is requested, the physician must obtain the consent of the patient or his authorized representative before releasing such knowledge. The patient's decision is final under the law. A physician may, within the limits of good taste, encourage the patient or his family to state the cause of illness, or the cause of death, when this information is requested by a bona-fide representative of the press. Where a person of public interest is involved, and the release of information has been authorized, the physician may arrange for regular bulletins concerning the person. The ethical physician will use restraint and good judgment regarding the use of his name in connection with such published reports.

4. Publications of photographs of physicians, who appear before recognized medical organizations, either in the official program of the scientific meeting or before the public press in connection with such meeting, is permissible. The use of photographs in the press when physicians are elected to office or when physicians are quoted by name on matters of general interest, not related to the care of a specific patient, is likewise permissible. Photographs of physicians in connection with civic or social affairs, not related to medical news or the care of patients, may be published unless the frequency of such photographs bespeaks self-exploitation. This applies also to magazine articles. Physicians should clear such publicity, whenever possible, with their county society.

5. The promise of radical cures or boasting of extraordinary skill or success is considered unethical by the medical profession because it is contrary to the best interest of the public.

6. For purposes of clarity, the following principles should guide physicians who appear on TV or radio programs or who are interviewed in other media of public information, such as newspapers and magazines:

   a. Doctors of medicine are expected to refrain from sponsoring products directly or by implication.

   b. When introduced as a doctor on TV or radio programs, or quoted in an article as a physician in newspapers and magazines, such individual cannot escape the implication of representing the medical profession and his conduct should be in keeping with the high standards of the profession.

   c. Sound judgment, good common sense and adherence to the *Principles of Medical Ethics* are expected of any physician when appearing on TV or radio programs, or in other media of public information, such as newspapers and magazines, in whatsoever capacity.

7. Members of medical society speakers bureaus, because of the very nature of their assignments, may be interviewed or quoted by the communication media. This is not considered unethical conduct.

   The members of these committees must be most circumspect and uphold the ideals of the medical profession.

8. At all times the doctor of medicine is expected to comply with the *Principles of Medical Ethics*. Section 10 of the *Principles of Medical Ethics* deals with relationships between physicians and the communications media. It says: "The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community." The Judicial Council construes Section 10 as encouraging physicians to work with the communications media as an integral and important part of the principle of upholding the responsibility of the physician to society as a whole.

   It shall be the responsibility of each county society to see that these *Principles* are not violated.

9. Doctors of medicine are ethically and legally required to protect the personal privacy and other legal rights of patients. The doctor-patient relationship and its confidential nature must be maintained. With these considerations in mind, the physician may assist the representatives of these media in every way possible.

Participation by Physicians in Bank Card Programs

The growth and development of credit cards is burgeoning. A new form of card, the so-called *bank card,* is being widely introduced. Bank cards are issued without cost to the cardholder; they are acceptable at many more places than conventional credit cards; they are sponsored by large, reputable banks. They are an innovation in our economic system.

As these bank card plans have come into being, in all parts of the country, physicians have asked if they may ethically participate in the bank card program and accept such a card as a form of payment for professional services. Some medical societies have said physicians may participate; others have said physicians may not.

The Judicial Council believes a uniformity of opinion is desirable. In matters of ethics it would seem indisputable that a general rule should be determined for the guidance of the profession, and that this rule should be implemented at local level.

The medical profession has officially recognized that it cannot dictate to patients how they shall finance their medical bills. It can and should, however, determine principles to guide its members in determining whether and how they may participate in any payment program.

If the bank card were merely a substitute for cash or check in the payment of bills, little or no problem would be presented to physicians regarding their use; they would be merely a newly adopted medium of exchange. Bank cards, however, serve a twofold function: They are a convenience—a substitute for currency or check in the payment of indebtedness; and they are also a financing mechanism. Consequently, their indiscriminate use, especially the financing of larger medical bills through banks, could result in additional cost to patients. While the doctor's fee for medical care would not increase, the cost of financing payment of that fee through a third party would be imposed on the patient. Of course, patients may voluntarily elect to pay larger amounts in return for the convenience of a given program. Still, the medical profession has a responsibility to guard against patients being placed in untenable financial conditions because of overall medical care costs. That is why medicine has been in the forefront in encouraging prepayment and insurance programs to provide for the costs of medical services. It must, therefore, maintain its position of safeguarding patients' interests when considering new methods of financing personal indebtedness.

The Judicial Council is of the opinion that neither endorsement nor disapproval should be given to the bank card system at this time.

In June, 1965, the Judicial Council and the Council on Medical Service jointly agreed that any proposed plan for financing medical care or parts of medical care should be judged by the physician in the light of whether or not it might "result in advertising or solicitation of patients by physicians, profit to physicians for other than professional services, exploitation of the patient, or unnecessary increase in the cost of medical care."

Judged by these criteria, the Judicial Council is of the opinion, at this time, that physician participation in bank card programs is not per se unethical. It is of the opinion that physicians may ethically accept bank cards in the payment of current medical bills in lieu of cash or check, that is, as a medium of exchange.

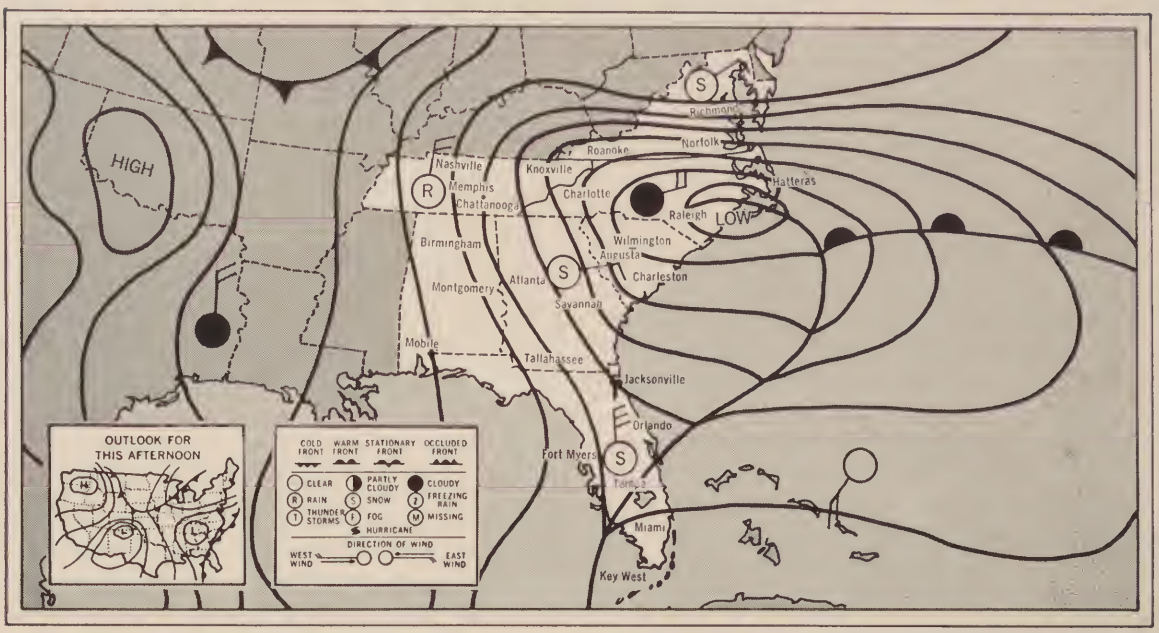
The use of bank cards in financing medical fees must, however, be viewed with reserve at the present stage of their development. While patients may not be denied the right to determine matters of their personal budgeting, physicians must not encourage the use of this financing method if in operation it might compromise the ideals of the medical profession or add to the financial burden of patients.

In connection with physician participation in bank card programs, the Judicial Council recommends the following principles to be implemented and applied as necessary by the county medical society for the guidance of physicians as these programs develop:

1. The county medical society should be satisfied as to the financial and professional integrity of the plan. It should negotiate with the plan sponsors to insure that service charges to the physician are reasonable. It should insist that the plan be open to all physicians on the same terms and that it not exploit or capitalize on physicians' participation in the plan. It should advise the plan that the listing of physicians

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Dosage: Adults—1 tablet, swallowed whole to preserve timed-release feature, in morning, midafternoon and at bedtime. *Side effects:* Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. *Precautions:* The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

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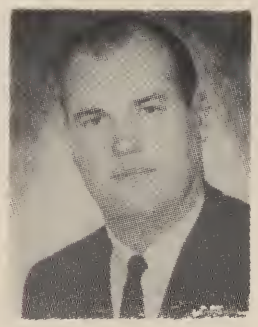
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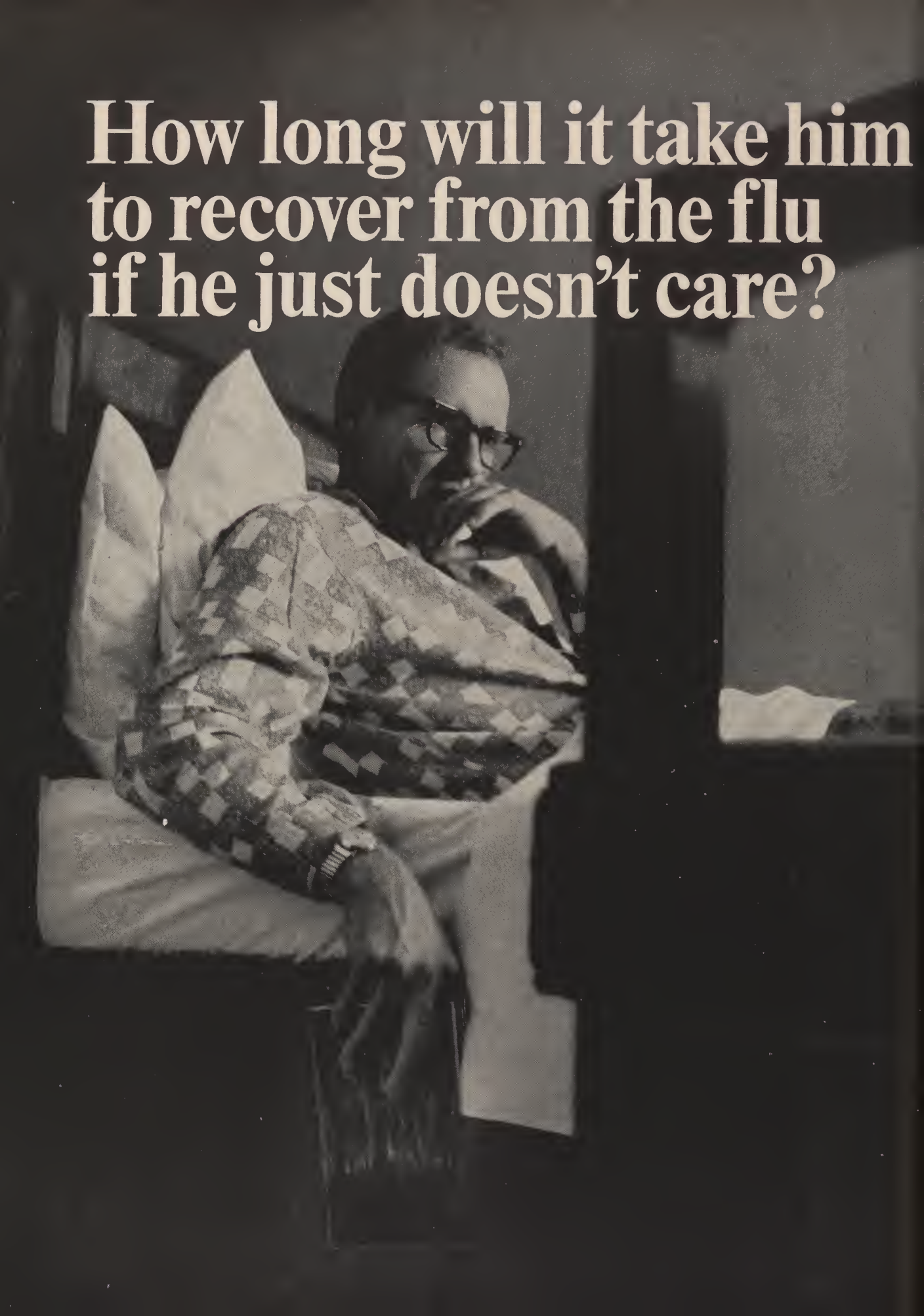


WILLIAM E. JOHNSON

in directories of participating members is contrary to the ethics of the medical profession.

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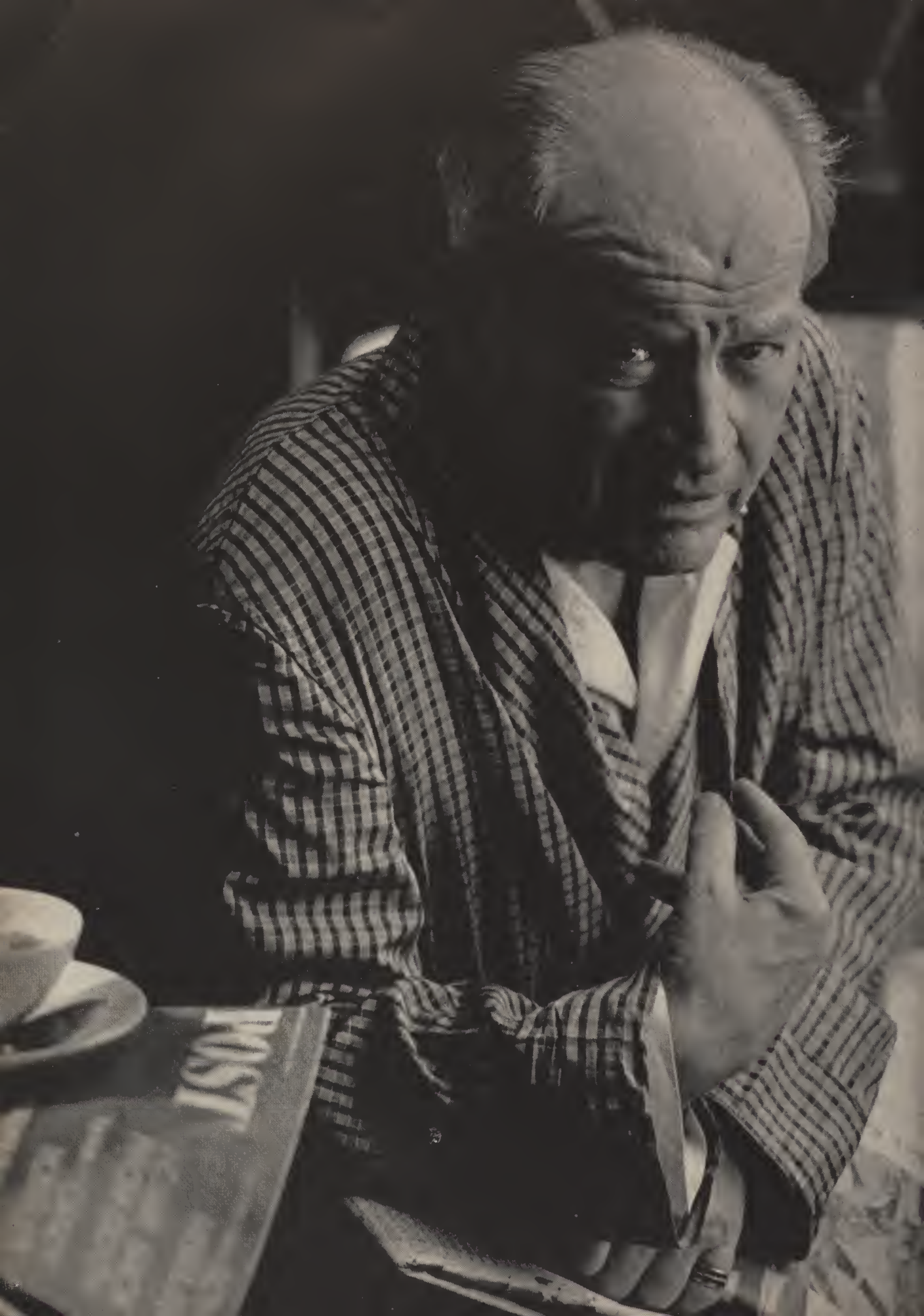
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SYMPOSIUM ON SHOCK

The Symposium on Shock was held at the February 3 meeting of the Baltimore City Medical Society. All five participating physicians are from the Clinical Shock Trauma Unit, the University of Maryland School of Medicine. The articles presented here are based on the talks given in the Symposium. The subjects and the authors, in the order of presentation, are as follows:

A Study of Shock and Trauma in Man Utilizing the Resources of a Clinical Shock Trauma Unit—R Adams Cowley, MD
The Nature of Refractory Shock—Arlie R. Mansberger, Jr., MD
Coagulation in Human Shock—Safuh Attar, MD
The Treatment of Shock in a Research Facility—Joseph S. McLaughlin, MD
A Clinical Shock Trauma Unit Looks at Future Therapy for Patients in Shock—Elwood H. LaBrosse, MD, PhD

A STUDY OF SHOCK AND TRAUMA IN MAN UTILIZING THE RESOURCES OF A CLINICAL SHOCK TRAUMA UNIT

R ADAMS COWLEY, MD
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University of Maryland School of Medicine

Severely injured individuals are constantly present in large general hospitals, particularly those associated with medical schools such as ours. While we do our best to treat these people, many deteriorate and die. Unlike most patients, who are hospitalized for acute or chronic disease and for whom some type of definitive therapy and care is planned, the accident- or emergency-ill victim becomes on admission an unwelcome patient since the hospital family is neither prepared nor geared to handle his emergency in a desirable manner. He is most likely to be seen by the least experienced house staff physician, the intern, during a period when time is of the essence and ripe clinical judgment is essential for his survival.

Today, shock and trauma therapy is often self-defeating for a number of reasons. Good care

From the Clinical Shock Trauma Unit, University of Maryland School of Medicine, Baltimore, Md. Supported by the US Army Medical Research and Development Command, Department of the Army, under Research Contact No. DA-49-193-MD-2229.

seems less than aggressive because young physicians who staff emergency rooms are ill-prepared to make even the first decisions that may be lifesaving. Decisions are often compounded by a compromise with inadequate treatment facilities, by harassment and pressure on a busy Saturday night with the intern, alone "on call," and by the impossibility of consultation because the senior staff member is busy in the operation room or treating another emergency on another floor. Could you, under these circumstances, provide care? Probably you could, but it would only be through mature *experience and judgment.*

Do you hear in your emergency room, "Get a chest x-ray!" and find the patient died while being turned on the x-ray table because an already stressed homeostatic system was thus overtaxed? Or, "Let's continue to watch the patient, he seems all right now," and know that precious minutes are lost at a point when rapid prophylactic resuscitation could have forestalled need for long, arduous refractory shock therapy? Do you hear, "Get the pressure up, start vasopressors!" and realize that he is reenforcing the vicious cycle of vasospasm while the lifesaving tissue perfusion ebbs away? Would not the simple technique of establishing a central venous pressure have given more information?

This present dilemma of emergency care can be expected because most medical schools have done little to teach trauma beyond minimal first aid and have structured student trauma education at the house staff level. Trauma and shock, as areas of special interest, have attracted few supporters.

The hospital attitude toward this problem is one of apathy in failing to provide the ancillary support so essential for proper care of the severely ill. Chemistry and blood gas laboratories are seldom available at night and on weekends when the incidence of accidental injury is greatest. Unavailability of proper x-rays, inadequate blood bank service, and the skeletal staffing of physicians and nurses on holidays and weekends, further handicap the *experienced* as well as the *inexperienced* physician.

These factors and many others perpetuate the same inadequate teaching, training and therapy experience year after year. It is little wonder, then, that young physicians who are so well trained in most other aspects of medicine are poorly equipped to make proper decisions for resuscitation and emergency care. In the event of disaster or war, their inexperience in this area could have a calamitous effect.

The public attitude toward tramua is one of indifference because in the experience of the layman the physical injuries that are seen are usually sudden, mutilating, distasteful, gruesome, and indicative of unlikely survival.* As a result, to the layman *perfunctory treatment is acceptable!* Many people are thus allowed to die by general consent since the physician, the hospital and the public have not accepted their responsibilities in trying to improve this desperate situation.

The total treatment of injured people on the basis of existing information is inadequate in most situations. Therapy continues to fall into a pattern of guess-work because the physician is unable to study the trauma patient who fails to respond to treatment. Scientific study and observation, along with good care, are synonymous with good therapy and the right of every patient. Inability to collect scientific information on what is taking place under conditions of therapy can only result in mediocre patient care. If scientific observations are not made during this period, the experience is lost and the physician is really not accepting his responsibility to the patient for he cannot otherwise guide therapy in the direction of decreasing mortality and morbidity due to accidental injury. Would it not be better if our profession solved the problem by converting all available resources into a plan for emergency care?

Awareness at the University of Maryland School of Medicine of problems related to injury and shock has resulted in the establishment of a Clinical Shock Trauma Unit (CSTU) to study the physiological, immuno-bacteriological and biochemical responses to injury in man. This unit has been in operation for the past four years. Since as far back as 1956, however, an extensive study of shock and its mechanism has been the major research interest of Dr. Robert W. Buxton and the Department of Surgery. The studies were initially limited to the animal experimental laboratory. As they progressed, two important factors became evident: (1) Although animal experimental work was necessary for many base line and

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* "Newspapers do not usually publish pictures of such injuries because they are horrifying and shocking to the public—people do not like to see them."—Sterling Noel, editor, *Baltimore News American.*

model studies, variance in response of different species indicated the necessity to study shock in man more directly; and (2) in order to understand the overall structural patho-physiological, immuno-bacteriological and biochemical alterations occurring in the organism, it was necessary to expand the program to include multidisciplinary support in order to explore effectively the basic phenomena occurring at the cellular level.

To date, we have studied shock in man with complementary support from animal investigation. The main features of the study are: (1) elucidation of physiologic and biochemical mechanisms of clinical shock, (2) development of therapeutic regimens, and (3) research and development of preventive measures.

The mechanisms of operation have included: (1) establishment of a Clinical Shock Trauma Unit for resuscitation, where pertinent data on trauma patients is collected on a 24-hour basis, and (2) modification of the animal research program in order to provide experimental data needed for support of observation in humans. Both the CSTU and the animal research program are operating effectively and, as a result, we have a large amount of previously unobtained clinical, physiological and biochemical data on patients in various types and stages of shock.

Preliminary analysis of the data already shows that it is not only feasible to study a state of a patient as manifested by various measured parameters, but it is also possible to investigate dynamic changes of these parameters and their mutual interdependence. This was our primary objective in collecting the data and required an extensive data analysis program.

Since inception of the study in January, 1962, over 300 patients in various stages of shock have been studied as they have undergone resuscitation measures. Some of our results have already been reported.[1-14] We believe we have proven that patients can be successfully studied during resuscitation; we have also demonstrated that the techniques developed and used have done much to improve therapy and to increase the survival rate. These experiences with the present CSTU now permit more complex studies of the physio-biochemical response to injury in man and constitute a solid basis for a second and even more fruitful phase of shock and trauma research. Hypotheses already formulated will now permit more efficient and more purposeful collection of data. Further analysis of both available and new data continues to yield additional tests of the formulated hypotheses and will lead to new conjectures that will make future shock research more challenging.

Steps taken by our group are only initial steps in specific areas of this neglected disease of modern society.[28] The responsibility for proper care of the emergency-ill lies with us all.

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THE NATURE OF REFRACTORY SHOCK

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Shock may be defined as a state of decreased perfusion associated with certain pathophysiologic and biochemical changes which are self-perpetuating and which, if uncorrected, lead to gradual deterioration of the patient. Much thought has been given in recent years to the effect of catecholamines on the peripheral vascular bed and there is healthy academic disagreement regarding mechanisms of response of the distal peripheral vascular components to the effects of increasing intravascular catecholamine titers. For example, capillary stasis in the later stages of shock has been attributed by some to the existence of venular sphincters that remain closed in response to endogenous pressor substances after the precapillary sphincter has relaxed. Others point out that this same stasis may be due to purely mechanical factors such as the Bernoulli effect on the thin walled venules secondary to lowering of venous pressure and the relaxation of arteriolar resistance.

However, there seems to be some general agreement among investigators in the "shock arena" that most low flow states, including shock from trauma, hemorrhage, sepsis and myocardial inadequacy, are associated with rising catecholamine titers and capillary ischemia, and with a later phase of stagnant hypoxia and plasma sequestration. Further, it is the consensus that data seem to relate the level of catecholamines not only to the severity of the low perfusion state, but also to the length of time it has persisted.

In any event, it would seem that closure of the arteriolar sphincter and the opening of arteriovenous (A-V) shunts must, of necessity, be associated with a change in the pressure relationships affecting the capillary so that the osmotic pressure would exceed the hydrostatic pressure and the net flow of volume would be from the extracellular space into the capillary. Since extracellular fluid has relatively little protein content, the net effect of extracellular fluid ingress should be a relative increase in water content, and a relative decrease in total protein, specific gravity and viscosity of fluid within the capillary. The above mentioned mechanism would seem to be a protective effort designed to enhance intravascular volume and ultimately capillary flow if the factors responsible for the hypotensive episode were corrected at this point in time.

Bypassing of capillaries results initially in ischemic hypoxia and, in order to survive, the cell must resort to anaerobic metabolism. The resultant increase in pyruvic acid and lactic acid (according to the formula DPNH and pyruvic acid $\rightleftharpoons$ lactic acid plus DPN) results in an environment of peripheral metabolic acidosis. The lowered pH is associated with a decreasing peripheral response to catecholamines, and increased amounts of norepinephrine and epinephrine are elaborated by peripheral sympathetics and the adrenal medulla, respectively. Continuation of the above phenomena with increasing acidosis eventually results in inability of the arteriolar sphincter to maintain tone in spite of dramatic increase in catechol levels. The resultant loss of arteriolar tone allows for the inflow of arterial blood into the capillary bed at the same moment the outflow is impeded by one of the mechanisms mentioned earlier in this discussion. Regardless of the mechanism responsible (and this author tends to favor the mechanical pressure effects rather than the theory of venular sphincter response to catecholamines) the net functional result is identical to that of a closed anatomical venular sphincter.

At this point in time of the shock cycle, the pressure relationships again change so that the hydrodynamic pressure within the capillary is greater than osmotic pressure and the net effect is the egress of intravascular fluid into the extracellular space. This phase, which might be called a phase of sequestration edema, is of course accompanied by "stagnant hypoxia," which further potentiates acidosis. The composition of the seques-

From the Clinical Shock Trauma Unit, University of Maryland School of Medicine, Baltimore, Md. Supported by the US Army Medical Research and Development Command, Department of the Army, under Research Contract No. DA-49-193-MD-2229.

tered fluid is predominantly water and electrolytes, since the larger molecular weight structures and red cells remain within the capillary. The increase in the viscosity of blood which occurs as a result of this sequestration phenomenon enhances rouleaux formation, sludging, and intravascular thrombosis. Intravascular thrombosis must in turn culminate in death of adjacent cellular structure and, of course, the ultimate in acidosis.

One of the known experimental effects of infused epinephrine is hepatic venous outflow obstruction and increased splanchnic bed inflow secondary to the opening of splanchnic A-V shunts,

The sum total of capillary stasis, sequestration edema, and splanchnic pooling, results in dramatic decrease in venous return, cardiac output and coronary flow. Cardiac efficiency is decreased in the presence of metabolic acidosis. Cardiac function eventually deteriorates to the point where cardiac arrest and/or fibrillation occur.

In 1966, we reported the findings of metabolic studies resulting from reversible low flow states in the human extremity prior to, during, and subsequent to, aortic cross clamping.[1]

In 15 patients undergoing elective resection of atherosclerotic aneurysms of the abdominal aorta, the femoral artery and vein of one extremity were exposed through a separate inguinal incision. Immediately prior to aortic and iliac artery cross-clamping, aliquots of blood were removed for study. Additional arterial and venous samples were obtained 30 minutes following occlusion, immediately prior to release of the cross clamps, and at 1 to 5, 10, 20 and 30 minute intervals following restoration of arterial continuity. Micro-techniques of the Astrup analyzer were utilized for the determination of pH, pO_2, pCO_2, standard bicarbonate, base excess and buffer base in all patients. O_2 saturation was calculated from the pH and pO_2 values. The method of Barker and Summerson was utilized to measure lactate levels, and pyruvate levels and were determined by a modified Friedman and Haugen technic. Excess lactate was calculated according to Huckabee:

$$\text{Excess lactate (XL)} = (L_n - L_o) - (P_n - P_o)\,(L_o/P)$$

L_o and P_o are control lactate and pyruvate

L_n and P_n are experimental lactate and pyruvate

In eight patients the serum water concentration, serum specific gravity and total proteins were

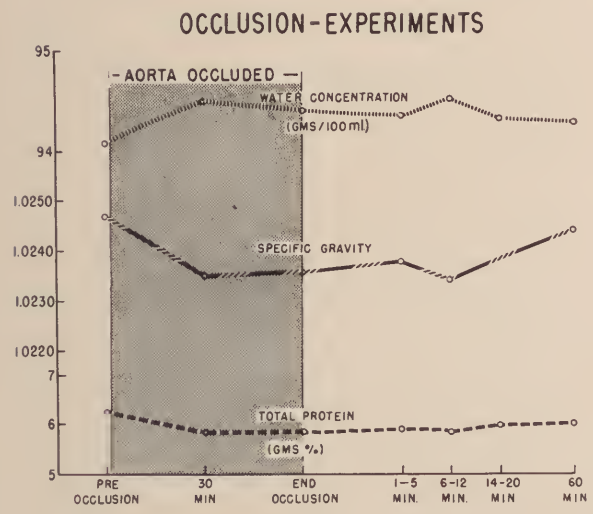


Fig 1

Mean values from femoral vein of eight patients illustrating fall in specific gravity and total protein and rise in water concentration suggesting net flow of interstitial fluid into capillary bed during occlusion.

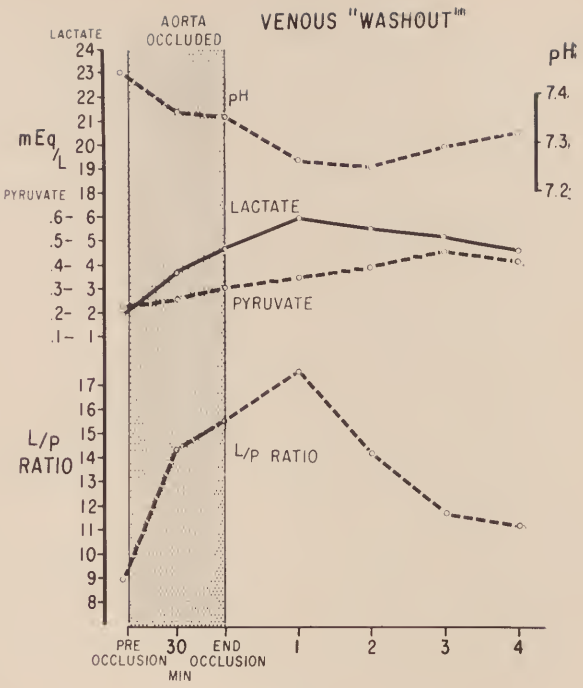


Fig 2

Mean values (total patient group) in femoral vein blood for lactate, pyruvate, L/P ratio and pH prior to and during occlusion, and at 1 to 5, 10, 20 and 30 minute intervals following aortic clamp release.

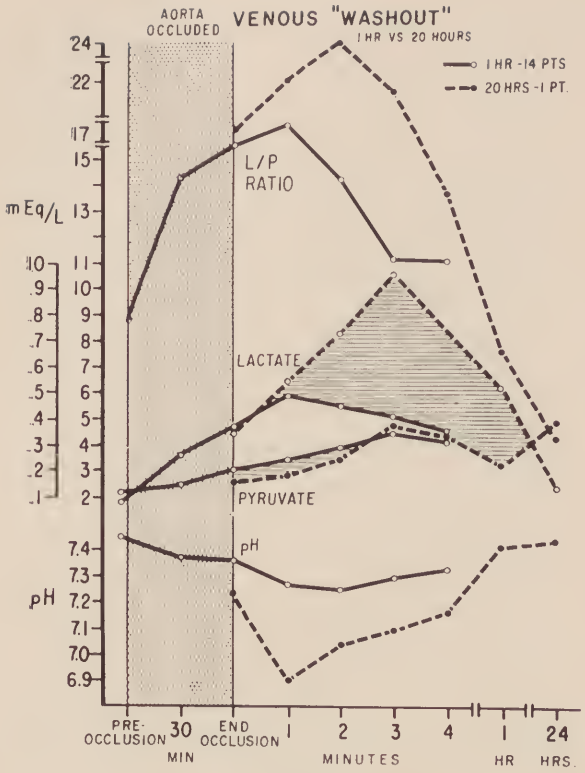


Fig 3

Illustrates the differences in femoral vein blood values for pH, lactate and L/P ratio between the mean of the total patient group and a single patient whose inflow was occluded for a total of 20 hours. (Sample times are as described in text.)

determined from the serum refractive index utilizing a total solids meter. Serum sodium, potassium, chloride and magnesium levels were analyzed in six patients by standard laboratory methods.

Halothane anesthesia was utilized on all patients following induction by pentothal, nitrous oxide and oxygen. Ten patients had intravenous infusion of commercial dextran into the upper extremity at a rate of 2.5 cc/kg body weight per hour. Five patients were infused with crystalloid solution only (5% dextrose in water).

Also studied was the venous "washout" of one additional patient who had successful restoration of arterial continuity following 20 hours of occlusion (inadvertant ligation of the right iliac artery during a left hemipelvectomy). One baseline arterial inflow sample only was obtained on this patient. Aliquots of blood obtained were analyzed as outlined in the preceding studies.

The results of these studies need not be belabored here since they have already been reported in detail.[1] A glance at Figs 1 through 5, however, suggests that metabolic changes resulting from decreased perfusion states include:

1. The accumulation of significant amounts of acid metabolites as evidenced by a significant fall in venous pH (Fig 2).
2. Significant elevation of the absolute value of lactate and pyruvate and of excess lactate during decreased perfusion (Fig 2).
3. A precipitous fall in serum specific gravity and serum protein concentration with concomitant elevation of serum water concentration (Fig 1).
4. A demonstration that metabolic changes resulting from ischemia are time-related (Fig 3).

The dramatic rise in venous pO_2 in control patients when compared to dextran-infused patients suggests not only the presence of A-V

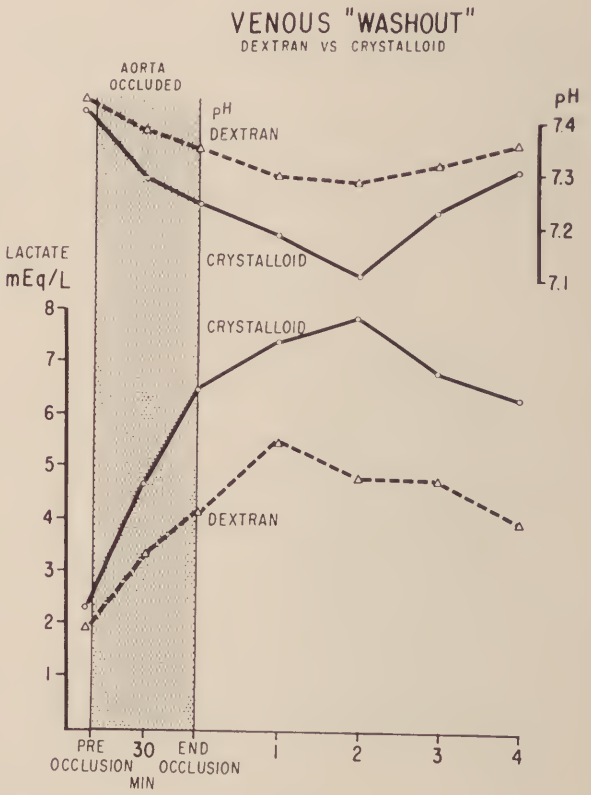


Fig 4

Illustrates differences in mean values in femoral vein blood for pH and lactate in those patients infused with dextran and those not infused with dextran. Post-release samples obtained at 1 to 5, 10, 20 and 30 minute intervals.

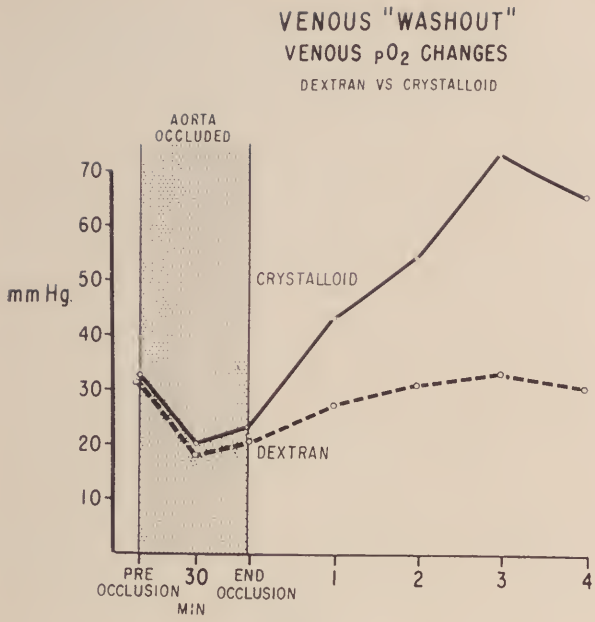


Fig 5

Comparison of mean venous pO_2 values (from femoral vein) in dextran-infused versus crystalloid-infused groups. Note post release increase in the latter group to values approaching those for arterial blood, suggesting the presence of A-V shunt in the human extremity. (Sample times are as described in text).

shunts in the human extremity, but also the efficacy of dextran in enhancing capillary flow (Fig 5). It is noteworthy that the venous pO_2 levels of those patients infused with dextran did not rise significantly, and at the same moment the metabolic changes were less severe, indicating enhancement of capillary perfusion and thus less need for dependence upon anaerobic metabolism (Figs 4 and 5).

These experimental findings would seem to enhance, at least in part, the validity of the thesis presented in the foregoing discussion on the nature of refractory shock.

The treatment of patients in refractory shock would seem to be best managed not only by avoiding the use of vasopressor drugs (except those which are pure beta adrenergic stimulators and thus enhance cardiac output), but also by altering the millieux for response to the patient's endogenous catecholamines, which are already present in adequate amounts.[2]

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COAGULATION IN HUMAN SHOCK

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The importance of altered hemostatic mechanisms and proteolysis in the pathogenesis and evolution of the shock syndrome has become apparent in our multidisciplinary approach to the problem of shock. Evidence for altered hemostasis in shock has been available in the experimental animals, but scarce in humans. The thesis of disseminated intravascular coagulation is advanced to account for altered hemostasis and hypercoagulability in shock, which ultimately leads to irreversible changes and death. This report is concerned with the study of alterations in coagulation and fibrinolysis in shock patients, the mechanisms leading to these changes, and therapeutic methods of altering such changes in order to improve the care and survival of shock patients.

This investigation was supported by the US Public Health Service Research Grant No. HE 09341-03 and by the US Army Medical Research and Development Command, Department of the Army, under research contract No. DA-49-193-MD-2229, and is from the Clinical Shock Trauma Unit, University of Maryland School of Medicine, Baltimore, Md.

Methods and Materials

Coagulation studies have been performed on more than 200 patients admitted to the Clinical Shock Trauma Unit (CSTU) of the University

of Maryland Hospital. The types of shock studied were: hypovolemic, septic, cardiogenic, toxic, and mixed type. A patient was considered in shock when the systolic arterial blood pressure was less than 90 mm Hg in the presence of acidosis, impaired renal function, bacteriological evidence of sepsis (septic shock), hypovolemia due to fluid and/or blood loss manifested by low central venous pressure that responds adequately to volume replacement (hypovolemic shock). Cardiogenic shock was defined as hypotension secondary to myocardial infarction, arrythmia or post-cardiac arrest.

Soon after admission to the CSTU, patients were cannulated and arterial samples were obtained initially and every six hours thereafter during the critical period. Blood samples were obtained once daily after stabilization of the clinical condition, until discharge or death.

Blood samples were obtained for the following studies:

A. Coagulation Studies
   1. silicone clotting time (Lee-White)
   2. fibrinogen
   3. prothrombin time
   4. partial thromboplastin time
   5. platelets
   6. platelet adhesive index
   7. clotting factors
   8. thromboelastography

B. Fibrinolytic Studies
   1. euglobulin lysis time
   2. plasminogen
   3. fibrin plate method of Astrup using heated and unheated plates
   4. Bradykinin

Data Analysis

A. Coagulation Studies

1. *Silicone clotting time*—Clotting time data were expressed in terms of a clotting index C, defined as follows: $C = \frac{T - Tn}{Tn}$ where T is the observed clotting time, and Tn is the normal clotting time. In this report the value chosen for Tn is 37, which is the rounded off mean of the range of 25 to 50 minutes. Clotting indices were plotted against time of sampling during and after the episode of shock. A complex of curves was obtained which, after curve fitting, resulted in Fig 1. A close examination of these curves shows that an oscillatory pattern of hypercoagulability followed by hypocoagulability could be demonstrated in all types of shock. In surviving patients, the changes in clotting times were less marked than in fatal cases, and returned to normal values upon recovery. In the fatal cases, clotting times were altered markedly following the same pattern of hyper- and hypocoagulability.

2. *Fibrinogen*—Changes in fibrinogen were triphasic. There was an initial decrease in the fibrinogen level followed by a marked and sustained elevation, especially in septic shock patients. This elevation returned to normal levels earlier in hemorrhagic shock patients than in patients with septic shock. A decrease of fibrinogen level to values ranging from 60 to 90 mg% was frequently associated with clinical deterioration and death in the types of shock studied.

3. *Prothrombin time*—This was a sensitive index of the clinical behavior of the shock patients. A gradually decreasing prothrombin activity below 40% of the control was invariably serious and was associated with a fatal outcome when it dropped to 30% or lower.

4. *Partial thromboplastin time*—This was used as a screening test for factors involved in the intrinsic prothrombin activation (V, VII through XII) (normal value between 78 and 90 seconds). In septic shock patients it was 117 $\pm$ 8.6 seconds in the survivors, as compared with 169.75 $\pm$ 14.98 seconds in the fatal group ($P<0.01$). It was also prolonged in cardiogenic shock: 157 $\pm$ 53 seconds in the survivors, as compared with 132 $\pm$ 14 seconds in the fatal group (not statistically significant).

5. *Platelets*—Platelet counts were made on whole blood, using phase contrast microscopy. The shock patients usually had counts below the normal range of 200,000-400,000 per mm,^{3} but the differences between the types of shock or between the survivors and non-survivors were not statistically significant.

6. *Platelet adhesive index*—The Platelet Adhesive Index (PAI) was obtained by counting the platelets in whole blood before and after passing 1 ml of blood through a tube containing 1 gm of glass beads. The shock patients often had PAIs (percent decrease in count) beyond the normal range of 25% to 60%, but the differences have

not been statistically significant because of large variations.

7. *Clotting factors*—These include Factors V, VII, VIII, IX, X, XI, XII and XIII. Multiple deficiencies were noted during shock, but were corrected toward normal with recovery, using blood, plasma or plasma concentrates.

8. *Thromboelastography*—The Hartert thromboelastograph[4] was used. This instrument registers completely the kinetics of fibrin clot formation, firmness, retraction and dissolution, and produces a permanent record. A close correlation has been obtained between the clinical progress of patients in shock and serial thromboelastograms. Fig 2 illustrates thromboelastograms of a 45-year-old woman who developed hypofibrinogenemia, shock and renal shut-down following delivery of a retained dead fetus. She did not respond to intensive fibrinogen therapy. Coagulation and fibrinolytic studies showed severe fibrinolysis that responded well to the antifibrinolytic agent, Epsilon-Amino-Caproic Acid.

B. Fibrinolytic Studies

An increase in fibrinolytic and proteolytic activity was demonstrated in all types of shock studied. The euglobulin lysis time which reflected changes in activator activity was markedly shortened during shock and gradually returned to normal values ($>$ 120 minutes) upon recovery. The same changes were reflected in the fibrin plate method and plasminogen determinations. Bradykininogen levels were also markedly decreased in shock patients, denoting its conversion to bradykinin, which is the most vasoactive polypeptide in the body and contributes significantly to the production of hypotension. Bradykininogen levels returned to normal or higher values during the recovery period, whereas it remained low in fatal patients.

Discussion

Significant alterations in the coagulation and fibrinolytic activities have been demonstrated in patients in hemorrhagic, septic, toxic and cardio-

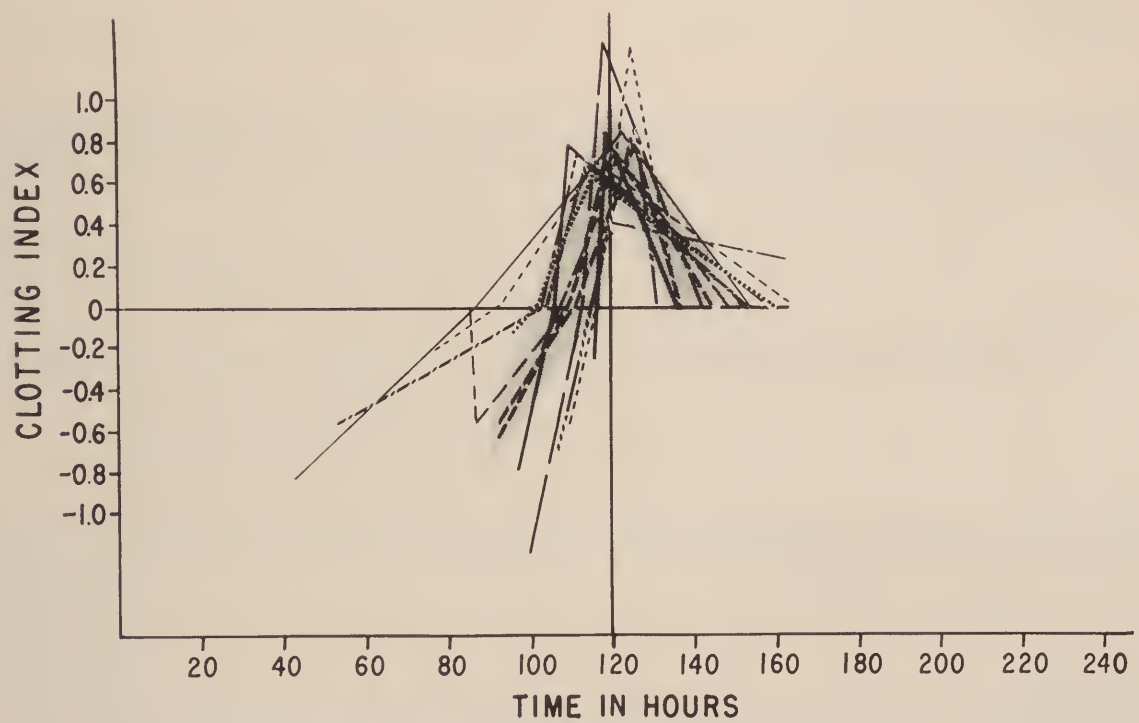


Fig 1
Clotting indices versus time in hemorrhagic shock patients who survived.

genic shock. These changes follow an oscillatory behavior with a reproducible pattern, dependent on the severity and duration of shock. The behavior of normal clotting is assumed to be an oscillatory one with small amplitudes. This is not demonstrated in our patients since they are seen after the onset of shock. Patients in shock exhibited an oscillatory pattern with higher magnitude and frequency. In surviving patients the pattern returned gradually to the assumed normal, whereas in the fatal patients the oscillations increased in amplitude and frequency. The interpretation of these oscillations in the coagulation mechanism in shock is rather difficult, since they represent the interaction of various opposing factors. The initial episode of hypercoagulability can be explained on the release of catecholamines and thromboplastic materials following lysis of platelets, plasma dilution of anticoagulant inhibitors, and early manifestation of the activation of the fibrinolytic enzymes. The hypocoagulable phase is as complex to explain as the phase of hypercoagulability. Following the hypercoagulable phase there is evidence of decrease of the clotting element, probably due to inadequate production by the liver, in the face of increased utilization. The increased anticoagulant and fibrinolytic activity contributes also to the consumption of the clotting factors, thus leading to hypocoagulability.

These coagulation and fibrinolytic studies not only are of diagnostic and prognostic significance, but also contribute to the management of patients in shock. Patients who exhibit marked hypercoagulability with evidence of disseminated intravascular clotting should be treated with anticoagulants, heparin, dextran, in contradistinction to patients in shock who manifest bleeding secondary to fibrinolysis. The latter has been treated effectively with antifibrinolytic agents such as epsilon-amino-caproic acid or trasylol. It is essential, however, to point out that serial coagulation and fibrinolytic studies are necessary for the proper management of this aspect of shock, since the pattern of clotting is varying rapidly with the progress of the shock state.

Summary

Analysis of coagulation and fibrinolytic studies in 200 patients in hemorrhagic, septic and cardiogenic shock is presented. An oscillatory behavior

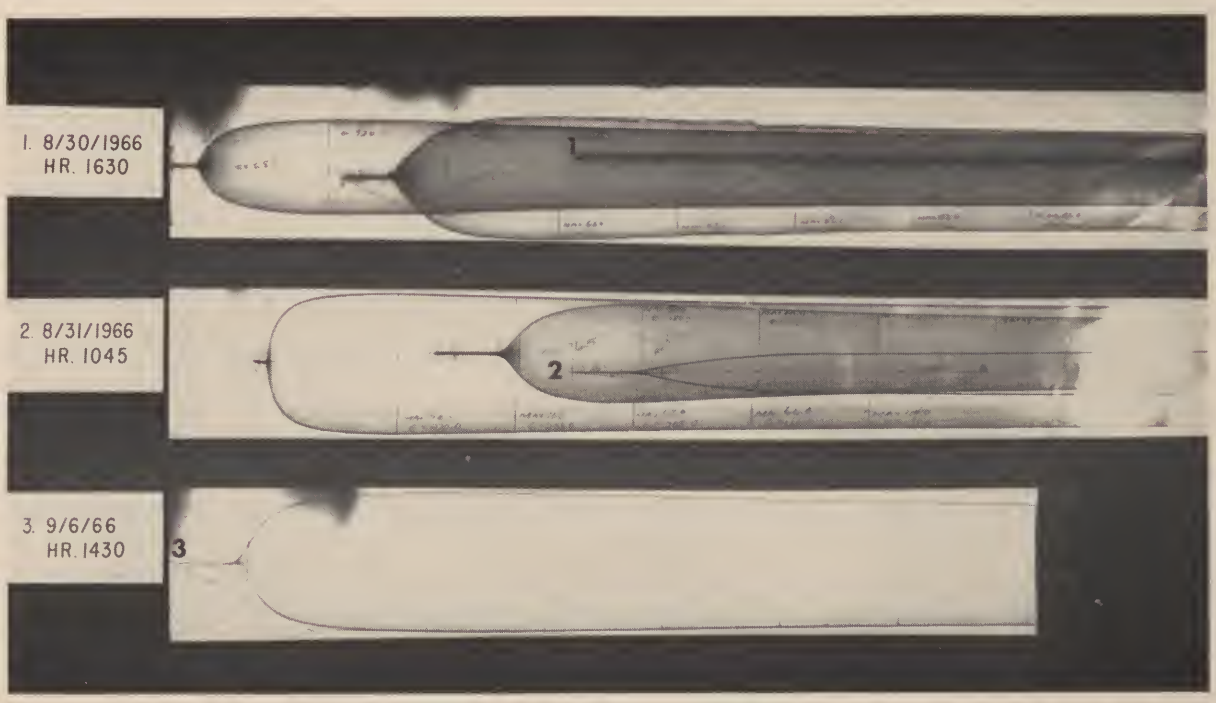


Fig 2
Thromboelastograms showing hypocoagulable blood in (1), with a poor clot, which has improved in (2), and normal clot formation in (3).

of the clotting mechanisms has been demonstrated. Although the same general pattern is obtained in fatal and non-fatal shock, the final outcome can be predicted by the amplitude and frequency of the oscillations. A prolongation of the silicone clotting time—frequently to unclottability, a significant decrease in fibrinogen, prothrombin activity, and marked reduction of clotting factors with markedly shortened euglobulin lysis time, were associated with a fatal outcome.

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THE TREATMENT OF SHOCK IN A RESEARCH FACILITY

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During the past four years of operation, the Clinical Shock Trauma Unit at the University of Maryland Hospital has demonstrated that the detailed study of numerous physiologic and biochemical processes can be carried out simultaneously and in conjunction with the therapy of critically ill patients. Indeed, the survival rate in the study group has been superior to that generally reported. Important information of basic scientific interest, as well as clinical and therapeutic knowledge, has been uncovered and this information has been and is being disseminated to the scientific community.

The feasibility of a clinical research area incorporating various medical and paramedical disciplines has been demonstrated. Within the next year, construction of a Shock Trauma Center incorporating an acute care facility, an operation room area with research facilities and an intensive care unit, will be initiated. This facility will provide the investigator with an opportunity to follow the patient during the complete course of his acute illness. Many of the research projects now being carried out in the Clinical Shock Trauma Unit will be continued in an expanded or extended manner. Other projects, heretofore not feasible, will be undertaken.

Parenthetically, the therapeutics of trauma are equally dynamic and improve as more fundamental descriptions are made. The University of Maryland Shock Trauma Center will provide the means of investigating trauma in depth without endangering the patient and, if past experience prevails, actually will increase his chances for survival.

The approach to shock therapy that is presently used in our unit is an uncomplicated one that can be carried out in any well-equipped general hospital and concerns itself with correction of four major factors: (1) the primary process, (2) volume deficits, (3) acid base and electrolyte abnormalities, and (4) specific organ failure.

Correction of the primary process: No system of treatment is completely adequate unless the

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primary process or cause of injury is corrected; therefore, appropriate measures to define and correct the primary process should be undertaken immediately. This should include a review of the history and physical findings and the appropriate laboratory data. Further, a tentative plan for treatment or, if indicated, additional investigation should be formulated.

Shock may be produced by a variety of mechanisms ranging from severe mechanical trauma to the entrance of bacteria and their toxins into the blood stream. At times, the primary process is obscure and only at a later date does the etiology of the shock episode become clear. This is particularly true in the case of septic shock. If definition of the primary process is not possible, septic shock must be suspected and appropriate frequent cultures of blood, urine and sputum obtained. Septic shock usually has been on the basis of gram negative organisms, often from the genitourinary tract; however, in recent years, the staphylococcus has been increasing in frequency as an etiologic agent. Wide spectrum antibiotics are administered intravenously. We utilize a combination of chloramphenicol and "staph-cidal" penicillin (Staphcillin®) in septic shock, or in shock of obscure etiology, until the cultures and sensitivity studies indicate that a change is in order.

Hydrocortisone in pharmacologic doses is indicated in patients in septic shock who do not respond to usual measures. This is not based on the treatment of adrenal insufficiency. Indeed, levels of cortisol in patients in shock are usually elevated, but experimental work by Lillehei et al has indicated that such dosages increase capillary perfusion by increasing cardiac output and decreasing arteriolar constriction.[1]

Correction of volume deficits: Except in the presence of heart failure, central venous pressure (CVP) has proven the most reliable measure of fluid therapy. Central venous pressure can be safely and accurately determined through a plastic cannula percutaneously inserted into the subclavian vein. The pressure is determined by the height of a column of saline adjusted to zero at the atrial level. Normal pressures in this system vary from 0 to 5 cm of saline; however, in the seriously ill patient in shock, the pressure must be higher if adequate circulation is to be produced. For pressures below 10 cm of saline, volume expansion is indicated. If the CVP is 10-15 cm saline volume expansion is usually indicated, but with a more cautious infusion, and a careful appraisal of the heart and lung status is carried out. A CVP above 15 cm of saline usually indicates myocardial failure and fluid replacement is counterindicated until this and other factors are evaluated and treated.

We have performed subclavian cannulation over 400 times without serious complication. Pneumothorax was produced twice: in both instances the problem was recognized by routine auscultation of the chest and appropriate measures corrected the problem.

The choice of an initial fluid depends on the type of shock present; however, it is generally agreed that colloid-containing solutions are indicated in most instances. This is based on experimental evidence demonstrating that the fluid lost or sequestered by the body in shock closely resembles plasma. In addition, there is much clinical data supporting the great value of colloid solution in a variety of shock states. Plasma is therefore infused in sufficient quantities to bring the arterial and venous pressure to acceptable values. Blood is substituted as soon as it is available in hemorrhagic shock and electrolyte solutions are added to the infusions as indicated. The choice of crystalloid solutions is dependent upon the patient's clinical state and the laboratory measurement of blood electrolytes. Buffered saline (Ringer's Lactate Solution) has considerable merit as an initial crystalloid solution and when infused simultaneously with plasma provides not only electrolyte, but free water for renal excretory function.

Correction of acid base and electrolyte abnormalities: The patient in shock usually is acidotic. The acidosis may be primary, ie, due to cation loss with body fluid, or secondary, ie, decreased tissue oxygenation leads to aneurobic metabolism and the production of acid radicals. Severe metabolic acidosis produces a decreased cardiac output and contributes to the viscous cycle of organ degeneration. This decrease in cardiac output has been well documented in animals and has been demonstrated to exist in a group of patients in shock studied in our Unit by Khazen.[2]

Treatment of acidosis is dependent upon improved tissue perfusion and oxygenation. Frequently volume infusion and adequate ventilation

are sufficient to return the acid-base balance to normal, the body ridding itself of the excess acid radicals through the lungs and the kidneys by the usual mechanism. However, in severe acidosis, where the normal compensatory mechanisms are maximally stressed, the infusion of base is necessary. Sodium bicarbonate is a logical agent since sodium stores usually are depleted and the bicarbonate ion is easily incorporated into the body's buffer system and subsequently excreted by the lungs. The Siggaard Anderson Curved Nomogram is utilized to estimate the base deficit, and the calculation of the amount of bicarbonate required to correct the metabolic acidosis, based on the Astrup formula for "bicarbonate space," has proven extremely reliable in the acutely ill patient.[3] Theoretical objections to this method exist, but in practice the correlation between the amount of sodium bicarbonate administered and the correction factor is exceedingly good. Our practice is to correct the acidosis using a solution of 1 mEq of sodium bicarbonate per ml of water slowly administered intravenously by hand injection.

Electrolyte abnormalities are common and are dependent upon the primary process, iatrogenic losses such as gastric suctioning, and mandatory and compensatory excretion by the body. Frequently educated estimates of these losses can be made from the patient's clinical status and the history. However, exact measurements of these abnormalities and their correction depend upon the biochemical laboratory as well as the measured output.

One of the more common electrolyte abnormalities in refractory shock is hyponatremia. While this may be produced by a variety of mechanisms, it is not uncommonly the result of the infusion of sodium-free fluids used as a vehicle for antibiotics, vasopressors and other medications during the post-traumatic antidiuretic period. Hyponatremia is associated with a decreased peripheral vascular response to epinephrine infusion in the experimental animal. In a recently reported series of refractory shock patients, a favorable response to concentrated sodium solutions was demonstrated.[4]

Correction of specific organ failure: The fourth factor in therapy are those efforts directed toward specific organ failure. The four organ systems usually affected are the heart, the lungs, the kidneys and the liver (reticuloendothelial system). Equally important is the fact that each of these organ systems initially may suffer only functional damage and, if properly supported, may demonstrate significant recovery.

The inability of the liver to perform many of its tasks during shock is well known. Carbohydrate and protein metabolism are affected and the body's major detoxification apparatus becomes non-operational. Attar has demonstrated marked impairment of the coagulation mechanism in the human in shock and Ollodart has shown a decrease in bacterial defense mechanisms in many of the same patients.[5, 6]

The principles of the treatment of hepatic failure are well known. In liver failure associated with shock, the establishment of an adequate circulation is all that is generally required to correct the overall deficit. Certain abnormalities such as those in the coagulation mechanism may at times require more specific therapy.

Renal failure is such a common occurrence with shock that its non-presence casts doubt upon the diagnosis. Dr. Barry has postulated that renal failure is first functional and only later becomes organic.[7] If urine output can be established, the latter condition can be avoided and he suggests the use of the osmotic diuretic mannitol as a means of establishing such flow. We have demonstrated marked impairment in renal function in humans in shock and in addition, have shown that in survivors renal function improves rapidly with the re-establishment of adequate blood pressure.[8] The use of osmotic diuretics frequently has not improved urinary output in those patients who did not demonstrate improvement with re-establishment of adequate circulatory dynamics and hydration; however, we still employ this agent because of the occasional dramatic improvement that does occur.

We have consistently demonstrated arterial blood pO_2 values much less than would be theoretically expected. This A-a gradient often persists and frequently worsens despite correction of ventilatory deficiencies by tracheostomy and mechanical respiratory assistance. Pulmonary function studies carried out in a small group of these patients have demonstrated increased shunting and increased physiologic dead space.

Initial treatment is directed toward insuring an adequate airway, free of secretion. Nasal oxygen

is administered routinely. If ventilation is clinically inadequate or if a pO_2 of less than 60 mm Hg is present, an endotracheal tube is passed and respiration is mechanically assisted. Tracheostomy in the hypoxic patient is hazardous and is more safely and easily performed with an endotracheal tube in place. In addition to the increased ventilation produced by the mechanical respirator, the work of breathing is greatly reduced. The latter is an important therapeutic factor in these seriously ill patients.

Myocardial failure may be the cause (primary myocardial failure) or the effect (secondary myocardial failure) of shock. Primary myocardial failure most commonly results from coronary occlusion and myocardial infarction. The initial muscle injury results in decreased cardiac output and causes a lowering of blood pressure. This decrease in cardiac output and blood pressure decreases coronary flow, which results in further injury to the myocardium. Vasopressors in these patients may reverse the process by increasing peripheral resistance and arterial blood pressure. Coronary blood flow is increased and the better nourished myocardium then may compensate for its injury. A similar viscous cycle may be present in the hypotensive patient without infarction. Decreased cardiac output and blood pressure result in diminished coronary blood flow which injures the myocardium and produces a decrease in myocardial contractile force. Diminished myocardial contractile force lowers the cardiac output and the blood pressure even further.[9]

Our approach to the problem of secondary myocardial failure in shock is based on the correction of the presenting pathophysiology. Initial efforts are directed toward the correction of volume deficits and acid-base and electrolyte imbalances. Frequently, correction of these abnormalities re-establishes adequate blood pressure and cardiac output, and subsequently coronary artery blood flow is increased. The viscous cycle is broken and the heart rapidly recovers from the insult. If the central venous pressure increases abnormally during the above therapy, digitalis in the form of Digoxin is administered intravenously. If the patient remains hypotensive and the central venous pressure continues to rise, circulatory support by adrenergic stimulating drugs is indicated. At present, it is generally agreed that two types of adrenergic receptors exist in the human circulatory system.[10] Alpha receptors produce peripheral arteriolar constriction, but have no direct effect on the myocardium. Since vasoconstriction and decreased tissue perfusion are two of the pathophysiologic abnormalities in shock, alpha adrenergic stimulating drugs appear to be contraindicated. Beta adrenergic stimulating drugs, producing both increased myocardial contractile force and arteriolar dilatation, theoretically should be ideal. At present, we utilize the beta stimulating drug isoproterenol, administered by intravenous drip (200 mcg/200 cc 5% D/W).

The blood pressure and cardiac output are brought to adequate levels and maintained by regulating the rate of infusion. Often, central venous pressure will decrease and urinary output will increase within a few minutes after the onset of the isoproterenol infusion. This allows the resumption of volume therapy if indicated: The infusion of fluid can be regulated by the central venous and arterial pressure response. Hopefully, adequate perfusion will break the viscous cycle of organ degeneration and allow gradual discontinuance of the isoproterenol.

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A CLINICAL SHOCK TRAUMA UNIT LOOKS AT FUTURE THERAPY FOR PATIENTS IN SHOCK

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Shock therapy today consists of fluid replacement to provide an adequate circulating blood volume, correction of electrolyte and acid base disturbances, assisting the failing heart, providing adequate respiratory exchange, and treating the initiating factor. These measures have been effective in resuscitating many patients in severe shock. In spite of the vigorous application of these methods, some patients do not respond to the treatment even when therapy has been promptly and adequately administered. It is these refractory patients that our CSTU is now studying from the biochemical and metabolic points of view. It is anticipated that information from these studies will permit us to establish guidelines for selection of therapy in the future.

Present information suggests that, in patients who do not respond to the currently established methods of treatment, there is a failure at the tissue level to utilize oxygen, even though the circulating blood volume has been restored, there is an adequate respiratory exchange in the lungs and there is an adequate cardiac output. As demonstrated in our laboratory,[1, 2] as well as in other laboratories,[3] evidence of a failure of utilization of oxygen at the tissue level is the fact that these patients show a continuing increase in blood lactate and pyruvate, which indicates that the tissues are metabolizing anerobically even though the oxygen supply has been raised to or toward the normal levels. This failure of oxygen utilization at the tissue level indicates that there is a breakdown in the intracellular transport and in utilization of oxygen at its reaction sites. These sites, where most of the oxygen reacts to provide energy for cellular function and reparation of injury, are located in the mitochrondria. Within these highly organized bundles of enzymes, oxygen is combined with carbon to form carbon dioxide, and with hydrogen to form water, by a series of step-wise and cyclic reactions known as glycolysis and the citric acid cycle,[4] and these are the reactions that produce energy and thus enable the cells to accomplish their many functions.

On the basis of this information, and stimulated by the successful results of treatment of carbon tetrachloride poisoning in rats by the administration of mitochondria, which has been reported by some German investigators,[5] Dr. Sadayoshi Hashimoto, working in our laboratories, has isolated and administered mitochrondria to dogs suffering from hemorrhagic shock.[6] The experimental hemorrhagic shock to which these dogs were subjected was a modification of the standardized procedure that has been described by Dr. Jacob Fine.[7] Under these experimental conditions, hemorrhagic shock is produced by withdrawing blood from the dogs into a reservoir until the blood pressure falls to 30 mm Hg and the blood pressure is kept at this level by additional withdrawal or retransfusion of the blood as necessary. When this period of hypotension has been maintained for a period of 2½ hours, the animals are then reinfused with their blood from the reservoir.

The method for the production of the experimental shock was the same in each of four groups. Group I, the control group (30 dogs), was untreated and had a survival rate of 17%. Group II ((22 dogs) was given a suspension of dog liver mitochondria (150 mg protein/100 ml of saline and 10 ml were given per kg body weight). The administration of the mitochondrial preparation, in this and each of the following groups, was started 30 minutes after the blood pressure

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reached 30 mm Hg and continued until the indicated dose, 10 ml/kg body weight, was completed. In Group II the survival rate was 59%. Because of the limited amount of dog liver which is available for preparation of mitochondria, Dr. Hashimoto next prepared the mitochondria from beef liver and lyophilized them to preserve their enzymatic activity. This preparation of lyophilized beef liver mitochondria was given to the animals (20 dogs) of Group III, at the same concentration as in Group II, and the survival rate was 80%. In order to obtain a more highly purified preparation (ie, one with a lower protein content), Dr. Hashimoto went to beef heart and fractionated the beef heart mitochondria into electron transport particles. Group IV (14 dogs) was given a saline suspension of the beef heart electron transport particles containing only 20 mg of protein/100 ml of saline, but the survival rate was highest, 86%, in this group.[6] The results of these investigations indicated that the administration of mitochondrial preparations had a highly significant effect on increasing the survival of dogs in experimental hemorrhagic shock.

In addition to these studies on dogs, rats—in experimentally induced hemorrhagic shock—have been treated with electron transport particles, and again in these animals a significant improvement in survival was observed. These results, therefore, suggest that treatment with mitochondria, or mitochondrial fractions, significantly increased the survival rate of animals that were subjected to experimental hemorrhagic shock. The exact mechanism of the action of mitochondrial fractions is not known, but in the group of animals given the smallest amounts of protein, namely the group of dogs treated with the beef heart electron transport particles, the amount of protein which was administered was less than 1/7 of that administered to the dogs which received dog liver mitochondria or lyophilized beef liver mitochondria, and yet the survival rate was comparable to that in the other group. This suggests that it was not the oncotic effect of these compounds which was of primary importance in survival, but the enzymatic activity of the fractions. An additional study was carried out by treating the electron transport particles with an enzyme inhibitor, rotenone. The particles treated with this compound no longer exhibit diphosphopyridine nucleotide dehydrogenase activity and yet their oncotic effect was unchanged. Rats which were subjected to hemorrhagic shock and were then injected with rotenone-treated electron transport particles had a survival rate not unlike the control group that received saline only. By contrast, there was a significant increase in the survival rate in animals which were given uninhibited electron transport particles.[8] This evidence suggests it is the enzymatic activity in the electron transport particles that is important for their effect on survival in shock. Further studies are necessary to clarify the mechanism by which these preparations increase the survival rate in the animals subjected to experimental shock.

Continuing studies in our laboratories further emphasize the importance of changes at the mitochondria level. Dr. Setsu Komatsu has investigated the oxygen uptake of mitochondria isolated from rats which have been subjected to experimental traumatic shock using the Noble-Collip drum.[9] These studies have revealed that mitochondria isolated from rats which have been subjected to traumatic shock have a significantly different response, namely in the respiratory control ratio, from mitochondria which are isolated from rats which have not been subjected to shock. This indicates that there is a difference at the mitochondrial level in animals which have been subjected to severe shock. Dr. Hirotoshi Shimizu, in our laboratories, has confirmed and extended the studies of Dr. Komatsu. Further work is in progress to define more completely the exact nature of these changes in the mitochondria.

The results of our studies up to the present time indicate that there is a significant change in the important intracellular organelles, mitochondria, as a result of shock, and that the treatment of animals which have been subjected to shock has shown an increase in survival when mitochondria, or mitochondrial fractions, have been administered. The use of these substances is aimed primarily at increasing the tissue utilization of oxygen by making the cells able to work more nearly at their normal efficiency. Additional investigation will be required to elucidate the mechanism of their therapeutic action.

A further approach to the therapy of shock is that of increasing the oxygen tensions at the cellular level, therefore forcing more oxygen into

the cells to bring its rate of utilization up to the normal levels.[10] This general approach has been made possible by the development of methods for administering oxygen at increased concentration and at increased pressure by a technique known as hyperbaric oxygenation, and is creating a new field of hyperbaric medicine. The technique of administering oxygen in a closed system at greater than atmospheric pressure makes it possible to increase the amount of oxygen dissolved in the plasma that can be carried to the cells even when there is a decrease in the amount of circulating red blood corpuscles. Under these conditions the oxygen tensions at the cellular level can be greatly increased. This method has the potentiality of "forcing" the oxygen into the cells at a higher rate, and for this reason it may promote oxygenation within the hypoxic cells even when the circulating blood volume is decreased. When the cellular utilization is decreased, this technique might prevent injury to the mitochondria. We believe that hyperbaric oxygenation has considerable potentiality for the treatment of shock.[7] As indicated above, however, the toxic reactions to 100% oxygen at pressures greater than one atmosphere make further detailed studies necessary. Numerous aspects of the application of hyperbaric oxygen to the treatment of pathological conditions have recently been described.[10]

The administration of mitochondrial preparations and other substances with enzymatic activity offers a potential method for increasing oxygen utilization and energy production. The modality of hyperbaric oxygen offers a means of increasing the oxygen supply at the intracellular level even under conditions of diminished transport. These are two promising methods which may be used for the future treatment of patients in shock, especially in the treatment of the patients who have previously been described as "refractory" because of their lack of response to the methods of treatment that are currently effective in the majority of cases.

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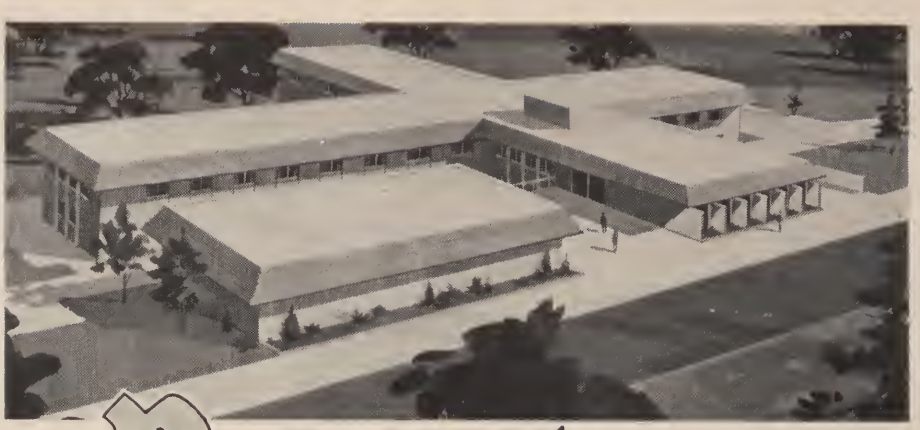
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PROGRESS AGAINST CANCER

The National Advisory Cancer Council reported that, although cancer is still on the increase, more people are being cured of it than ever before.

Entitled "Progress against Cancer," the report shows that 30 years ago there were 144,774 cancer deaths in the United States, a crude rate of 112.4 per 100,000 of the population. In 1967, an estimated 305,000 deaths will occur, bringing the rate up to 153 per 100,000, according to the report. On the other hand, there has been an improvement in the cure rate. In 1937, less than one in five cancer patients survived five years without evidence of disease, but currently about 35 per cent, or better than one in three are saved. There is good reason to believe, the report states, that this favorable trend will continue.

From an AMA news release, Jan, 1967.



THE Regent

Nursing & Rehabilitative Treatment Center

Offering full treatment to the adult physically handicapped, specialized care to the senior citizen, and convalescent care to post-stroke and post-operative cases. Separate area for cancer patients. *All facilities available to private physician.*

Professionally staffed and equipped Physical Therapy gymnasium, under the direct supervision of a specialist in physical medicine. There is also an organized program of recreation.

Everything at The Regent is designed to be used by wheel chair patients.

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TRANQUILIZER IMPACT ON PSYCHIATRIC TREATMENT

Of the host of drugs used in psychiatry today, the major tranquilizers are clearly the best, according to Jonathan O. Cole, MD, of the National Institute of Mental Health, US Public Health Service.

Studies directed by the Institute show that two-thirds of newly-admitted schizophrenic patients improve markedly in six weeks on these drugs, known as phenothiazines, Dr. Cole said. They have sped the release of patients from hospitals at a saving of some $2 billion in hospital costs alone. Losses in patient earning power would raise the figure much higher, he declared. These drugs can cause mildly uncomfortable side effects, but they are usually tolerable. They have facilitated new patterns of treatment, such as day care clinics and community centers, and have prevented altogether the hospitalization of many patients, he added.

Dr. Cole, an international authority on drugs, spoke on February 20 at the Lowell Lecture Series sponsored by the Tufts University School of Medicine in Boston. He heads the Psychopharmacology Research Branch, NIMH, the Federal unit which supports research on drugs that act on the mind.

The value of other drugs in general usage for emotional disorders range from moderately effective to almost useless, according to Dr. Cole.

From NIMH news release, Feb 21, 1967.

New from Du Pont

Symmetrel®

(Amantadine HCl)

The first oral chemical virostat for the prevention of influenza A_2



Influenza virus
Protein shell enclosing the core of nucleic acid (RNA)—artist's representation

The incidence of influenza A_2. In this country, where influenza is one of the leading causes of morbidity, influenza A_2 (Asian) continues to be a serious medical problem. In 1957 influenza A_2 was responsible for approximately 40,000 excess deaths in a three-month period. Since that year the most prevalent influenza virus has been A_2 (Asian).

What is Symmetrel®? "Symmetrel" (amantadine HCl) is a new synthetic chemical which acts as a molecular barrier to virus penetration. It provides for the first time specific oral medication for the prevention of respiratory infections caused by influenza A_2 (Asian) viruses—an entirely new approach in preventive medicine.

For prescribing information, see last page of this presentation

What Symmetrel® (amantadine HCl) means to you

...the first and only oral chemical agent to prevent influenza A_2 (Asian).

...not a vaccine or antibiotic, but a new synthetic chemical unrelated to any other chemotherapeutic agent.

...unique mode of action: prevents virus penetration of the host cell without affecting vital cell functions.

...specifically active against all influenza A_2 viruses tested to date.

...not indicated for the prevention of influenzal or respiratory illness other than influenza A_2 or for the treatment of established disease.

...does not interfere with normal antibody response; acts in concert with pre-existing antibody.

What Symmetrel® means to your patient

...possible immediate influenza A_2 protection when taken following suspected contact.

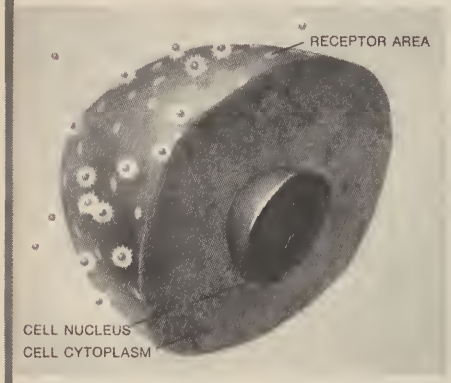
...may be particularly useful during outbreaks or epidemics and for high-risk patients in whom the occurrence of influenza A_2 is especially hazardous.

...a high degree of safety in clinical use.

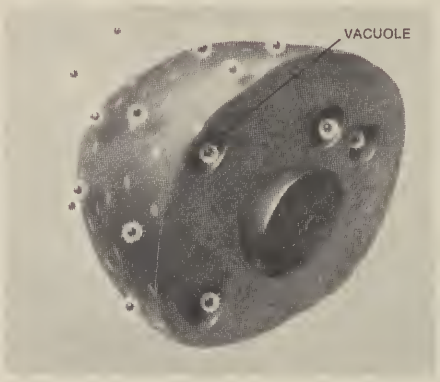
...simple once daily or b.i.d. dosage.

The mode of action of Symmetrel®

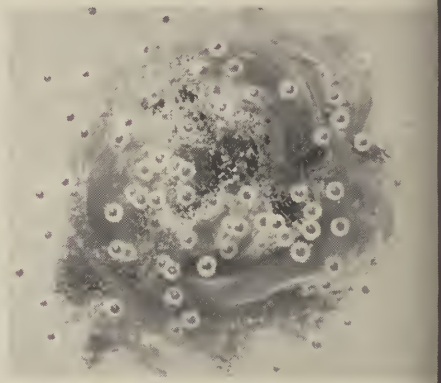
How the influenza virus invades and destroys the untreated cell



1 Viruses outside the cell attach themselves to specific cell receptor areas

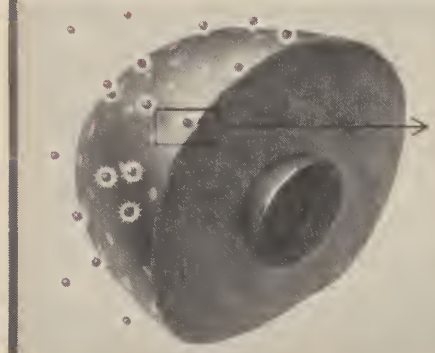


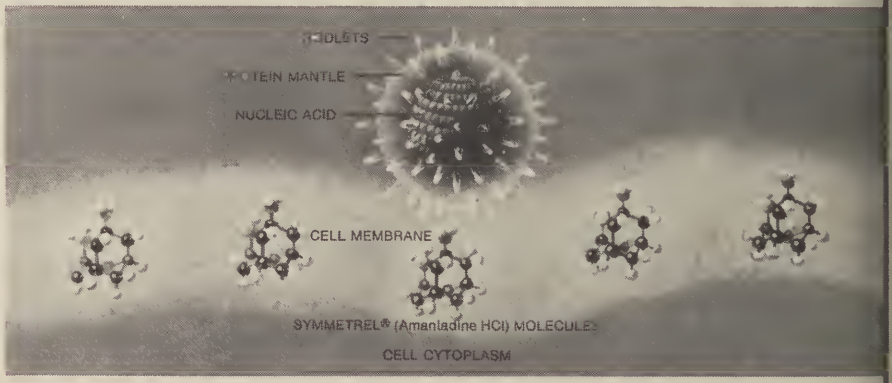
2 The virus is incorporated into a vacuole within the cell. From this vacuole the virus nucleic acid passes into the cell cytoplasm



3 The virus nucleic acid then directs the cell to produce both new virus nucleic acid and virus protein coat material which aggregate to form new virus particles. This process leads to the release of new virus particles and eventual destruction of the cell

How Symmetrel® (Amantadine HCl) prevents virus invasion[1]





Our current knowledge leads us to believe "Symmetrel" acts as a molecular barrier to influenza virus penetration. Shown here in a greatly enlarged section, "Symmetrel"—located at the cellular membrane—effectively prevents (blocks) virus penetration. Thus, "Symmetrel" does not directly destroy the virus particle but acting as a virostat prevents the cycle of virus penetration, virus replication, and cell destruction that is characteristic of virus invasion of animal cells (tissue). *Artist's conception based on current scientific knowledge.*

1. "Mode of Action of the Antiviral Activity of Amantadine in Tissue Culture", Hoffmann, C. E.; Neumayer, E. M.; Haff, R. F.; and Goldsby, R. A., Journal of Bacteriology *90*,623 (1965).

Safety of Symmetrel® Confirmed. When used as indicated, is generally well tolerated. No kidney, liver, bone marrow, or hematological disturbances have been observed.

Prescribing Information

Indications: "Symmetrel" is indicated for the prevention (prophylaxis) of influenza A_2 in persons of all age groups. Early use is recommended, preferably before or as soon as possible after actual or suspected contact with individuals suffering from influenza A_2. "Symmetrel" should especially be considered for high influenza-risk patient groups such as those suffering from chronic debilitating diseases and elderly persons.

Contraindications: Not indicated for the prevention of influenzal or respiratory illness other than influenza A_2 or for the treatment of established disease.

Warnings: Administration to patients with central nervous system disease, particularly geriatric patients with cerebral arteriosclerosis, and patients with a history of epilepsy or other "seizures," requires strict observation for possible untoward effects (see Adverse Reactions). Patients taking psychopharmacologic drugs, central nervous system stimulants, or alcoholic beverages should be observed for possible evidence of intolerance. Those patients who experience central nervous system effects or blurring of vision should be cautioned against driving or working in situations where alertness is important.

No teratogenic effects have been seen in reproductive studies in rats and rabbits. Studies in pregnant women have, however, not been done and use of this drug in women of childbearing age should be undertaken only after weighing the possible risks to the fetus against benefit to the pregnant patient. It should not be administered to nursing mothers since it is not known whether the drug is secreted in the milk.

Precautions: Ineffective against bacterial infections. Patients should be observed for idiosyncratic reactions as with all new drugs. Geriatric patients with pre-existing serious medical illnesses with mental or physical deterioration should be followed carefully medically while taking "Symmetrel." (See Adverse Reactions.)

Adverse Reactions: With higher than indicated doses manifestations of central nervous system effects such as nervousness, insomnia, dizziness, lightheadedness, drunken feeling, slurred speech, ataxia, inability to concentrate and some psychic reactions including depression and feelings of detachment were seen. Occasional blurred vision was reported at higher doses. Some of the milder and less pronounced symptoms above have been reported in a small number of patients taking the recommended dosage of 200 mg per day. Those were mostly transient and disappeared with continued administration of the drug. Some geriatric patients developed paranoid or hallucinatory behavior and became unmanageable while taking 200 mg daily. Medically unselected seriously deteriorated geriatric patients showed poor clinical tolerance after several weeks of daily dosing with 200 mg per day. One elderly patient with a history of prior cerebrovascular accident developed visual hallucinations and grand-mal convulsions while on drug at 800 mg per day. Some cases of dry mouth, gastrointestinal upset and skin rash and rarely, tremors, anorexia, pollakiuria, and nocturia have been also reported.

Safety: When used as indicated, is generally well tolerated. No kidney, liver, bone marrow, or hematological disturbances have been observed.

Dosage: *Adults:* Two 100 mg capsules (or 4 teaspoonfuls of syrup) as a single daily dose or the daily dose may be divided into one capsule of 100 mg (or 2 teaspoonfuls of syrup) twice a day.

Children: 1 yr.—9 yrs. of age: Calculate total daily dose on the basis of 2 mg to 4 mg per pound of body weight per day (but not to exceed 150 mg per day). Daily dose, given as the syrup, should be given in 2 or 3 equal portions.

9 yrs.—12 yrs. of age: Total daily dose 200 mg given as one capsule of 100 mg (or 2 teaspoonfuls of syrup) twice a day.

How Supplied: *Capsules:* Bottles of 100. Each red, gelatin capsule contains 100 mg amantadine HCl.
Syrup: Bottles of 1 pint. Each 5 ml (1 teaspoonful) contains 50 mg amantadine HCl.

DUPONT

Symmetrel®

(Amantadine HCl)

A molecular barrier to virus penetration



NEW EVIDENCE:

Pro-Banthīne® (propantheline bromide)
gives positive, selective benefits in gastrointestinal disorders.



Intragastric photograph of pyloric region showing complete relaxation of pyloric sphincter with 6 mg. of Pro-Banthine intravenously.

AN IMPORTANT PROBLEM in managing gastrointestinal disorders has been the choice of an anticholinergic agent which will act positively and selectively on the gastrointestinal tract without extensive secondary effects.

Recent direct observations with the cinefibergastroscope and intragastric photography[1] visually confirm previous evidence that Pro-Banthine does, indeed, possess such selective activity.

Barowsky and his associates demonstrated that a minimal dose of 6 to 8 mg. of Pro-Banthine intravenously produced complete relaxation of gastric activity. Secondary effects were not significant.

By contrast, it required 0.8 mg. or double the usual dose of atropine intravenously to achieve similar gastric relaxation. Side effects of this dosage of the belladonna alkaloid were pronounced. Ventricular rates were as high as 150 per minute.

For positive, selective anticholinergic benefits Pro-Banthine is indicated in patients with peptic ulcer, gastritis, irritable colon and other forms of gastrointestinal hypermotility.

Dosage: The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type ampuls of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

Contraindications: In glaucoma or severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in the elderly male with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug.

Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

Side Effects The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

1. Barowsky, H.; Greene, L.; Bennett, R., and Buganza, G.: The Effect of Anticholinergic Drugs on Gastric Motility and Pyloric Function, Scientific Exhibit, Annual Convention of the American Medical Association, Chicago, Illinois, June 26-30, 1966.

SEARLE *Research in the Service of Medicine*

When the battle with bacteria is in the upper respiratory tract

Routes of invasion through the oral and nasal passages to the nasopharyngeal mucosa: artist's depiction of sagittal section of head in perspective.



consider Gantanol (sulfamethoxazole)



To rapidly help the patient win against upper respiratory infections

When the respiratory tract has been invaded, an antibacterial that can assure effective yet generally uncomplicated therapy is your first line of defense...an agent such as Gantanol (sulfamethoxazole), the wide-spectrum antibacterial from Roche.

Gantanol (sulfamethoxazole) is effective against common susceptible upper respiratory pathogens, both gram-positive and gram-negative. Acting at foci of bacterial invasion, Gantanol (sulfamethoxazole) promptly helps control most infections, yet usually presents few problems to patients. Dosage is convenient and provides a measure of economy.

Before prescribing, please consult complete product information, a summary of which follows:

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, or newborn infants during first three months of life.

Warnings: Use only after critical appraisal in patients with liver damage, renal damage, urinary obstruction or blood dyscrasias. If toxic or hypersensitivity reactions or blood dyscrasias occur, discontinue therapy. In intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed.

Precautions: Observe usual sulfonamide therapy precautions, including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus or rickettsial infections.

Adverse reactions: Headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, Stevens-Johnson syndrome, injection of the conjunctiva and sclera, petechiae, purpura, hematuria or crystalluria may occur, in which case the dosage should be decreased or the drug withdrawn.

Dosage: Adults—4 tablets initially, then 2 tablets b.i.d. or t.i.d. depending upon severity of infection. Children—1 tablet/20 lbs initially, followed by ½ tablet/20 lbs b.i.d.

How supplied: Tablets, 0.5 Gm, bottles of 50.

Roche Laboratories, Division of Hoffmann-La Roche Inc., Nutley, N. J. 07110

When there are bacterial invaders in the upper respiratory tract

Gantanol®
(sulfamethoxazole)

ROCHE



"Yes, Doctor, the pain is gone."

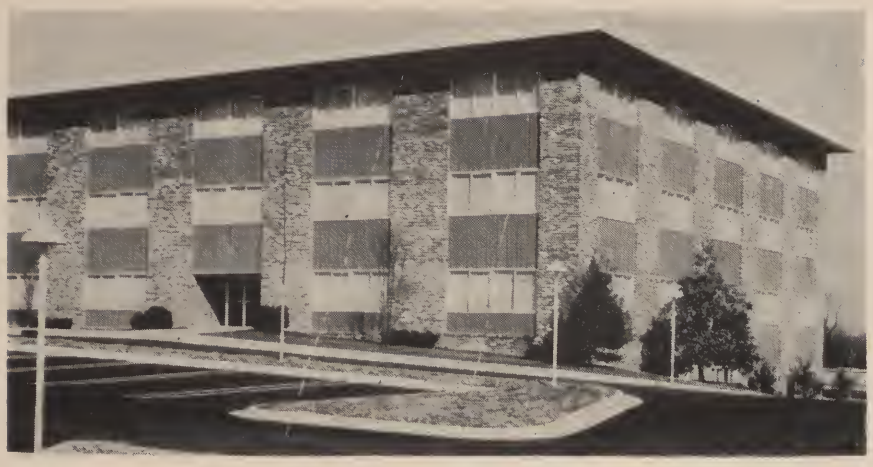
■ Despite introduction of synthetic substitutes, efficacy of 'Empirin' Compound with Codeine remains unchallenged.

'Empirin'® Compound with Codeine Phosphate gr. ½ No. 3

Each tablet contains: Codeine Phosphate gr. ½ (Warning—May be habit forming), Phenacetin gr. 2½, Aspirin gr. 3½, Caffeine gr. ½.

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PRESIDENT'S MESSAGE ON CHILDREN AND YOUTH

On February 10, the President submitted his special message to the Congress on children and youth. Among other things, he recommended an increase in appropriations of $100 million to provide medical care for needy children under the Title XIX program. He also requested full authorization of $40 million for the comprehensive health service program for preschool and school children.

The President said, "There are only 12,000 trained pediatricians and 13,000 obstetricians in the United States today—far too few to provide adequate medical care for all our children and mothers."

The President also recommended legislation to authorize 10 pilot centers in 1967 to provide research and development for child health care and to provide care for 180,000 needy children and 10,000 mothers. The new centers will be associated, whenever possible, with medical universities or neighborhood health centers. He advised that he is directing the Secretary of Health, Education, and Welfare to allocate increased funds to help train pediatricians, obstetricians, and family doctors with respect to mental retardation, as well as seeking federal support for the staffing of community mental health centers.

From a news release of the AMA Council On Legislative Activities, Feb 10, 1967.

MEDIC: A COOPERATIVE VENTURE IN CONTINUING MEDICAL EDUCATION

F. J. HELDRICH, JR., MD
Chairman, Subcommittee on Continuing Education Medical and Chirurgical Faculty of the State of Maryland

Director, Continuing Medical Education Maryland State Department of Health

In October 1965, a chain of communication was formed among several of the community hospitals of the State of Maryland for the purpose of disseminating programs of medical interest among Maryland physicians. This represented an attempt to circumvent two major obstacles that minimize the effectiveness of many programs of continuing medical education: time and distance. These two factors had been repeatedly referred to during discussions with interested physicians in the community hospitals of the State, and their opinions had been corroborated by those of the Medical Education Committee of the Hospital Council of Maryland. Since the obstacles of time and distance confront both the medical educator and the practicing physician, it was agreed that they deserved primary consideration in any attempt to improve the effectiveness of the processes of continuing medical education.

Philosophy: From the beginning it was recognized that the matter of continuing medical education for the physician is basically a personal one and that each physician will meet his needs in the manner he deems most appropriate. Through lectures, case presentations, courses and seminars, attendance at society and professional meetings, reading, "curbstone consultations" with his peers, referral letters, films, records, television tapes, and correspondence courses, the physician is continually striving to meet this need. All of these methods have merit. Depending on the personal judgment of each physician, some have greater appeal than others.

While not attempting to detract from any of these methods nor to imply that there is necessarily a best way to accomplish this end, many felt that scheduled programs on a recurring basis, offered in the community hospitals in which the physicians work, might be a worthwhile addition to post-graduate medical education. The sharing of medical programs given in one hospital with physicians throughout the State held promise of several unique benefits: hospitals with limited resources for developing programs of medical education would be assisted, the number of educational opportunities available to all would be increased, and the medical education thus provided would become part of the working day rather than make further inroads on what little free time is available to physicians. These concepts seemed worth testing.

General hospitals were chosen as the focal points for programs of continuing medical education because all physicians in the State have ready access to at least one of them. Following the overall pattern of population density, 44 such hospitals are distributed throughout Maryland. Few of the State's physicians live more than 30 miles from a general hospital and most live much closer. A high percentage of the physicians in the State are affiliated with one of these community hospitals and usually go there during the

course of a day. Travel time and distance were thus seen to be reducible to a minimum through the use of these locations.

To accommodate the physician further, we remained cognizant of his heavy workload. It is not realistic to expect any physician to cancel out large segments of time ordinarily devoted to patient care, nor would it be fair to the patients. It would only add to medicine's present manpower shortage. We therefore felt we should strive to present programs of *general* medical interest during the times when the largest numbers of physicians are able to attend, programs of *special* medical interest at times when those most interested in these specialty programs are free, local programs dictated by the preferences of local physicians, etc. At best, his attendance entails an appreciable sacrifice on the part of the physician. To lose sight of time and timing would have been a grievous error.

Sharing of programs among the physicians of the community hospitals seemed especially appealing to the smaller hospitals and to those farthest removed from the teaching centers. Certainly, some of the community hospitals have excellent intramural programs of continuing medical education, but the benefits from their programs are limited to the physicians who attend at those locations. Almost everyone agrees that personal attendance is preferred, but not really possible except for those in immediate proximity to the point of program presentation. A means of bringing these programs to physicians in their own hospital setting was therefore a basic objective.

Method: Exploring the means of accomplishing this led to an investigation of several media. It was initially agreed that we in Maryland desire privacy and feel that it should not be compromised. There was one other limitation—the cost had to be borne by the physicians themselves. With these limitations in mind, the possible means of accomplishing our aims were investigated.

Inquiry concerning television soon established



Fig 1

Physicians in local hospital receiving a MEDIC broadcast. Note the slide projector used for slide presentation and next to it the telephone by which the physicians at this hospital may speak over the network. The voice of the lecturer is coming through the small speaker located just below and to the right of the screen.

the fact that no facilities—other than public television channels—were available in the State. For us, a statewide educational television network that might be adapted to our needs was still in the drawing board stage. Radio was available—FM radio—but investigation of cost revealed it to be financially prohibitive on a cost-per-hours-used basis.

Further investigation revealed that Dr. John Tuohy, at Saint Agnes Hospital in Baltimore, was employing a suitable method—the telephone. Accordingly, MEDIC (Medical Education's Dedicated Instructional Channel) was established. By means of this telephone linkage among the community hospitals of the State, the spoken word is transmitted simultaneously to all participating hospitals. A suitable loud-speaker, the size of which depends upon the size of the conference area used, is placed in each hospital. All programs are heard over these speakers, which are nothing more than magnified telephone ear pieces. Not only can physicians listen over this network, but they can also reply and/or ask questions and, in effect, carry on conversation among themselves. To talk over the network, the speaker uses either a telephone handset or a microphone (depending, again, upon the size of the room in which the equipment is located). To supplement this voice transmission, slides and other pertinent material are duplicated and distributed to all of the participating hospitals before the presentation. These are then used in each location during the program. As the talk progresses, the slides are projected on the screen at each community hospital in response to the lecturer's request. Perhaps the end result may best be dubbed "horse and buggy television." A typical local audience receiving a MEDIC program is pictured in Fig 1.

Financing: Funds to make this system operative come from three basic sources. In each of the participating hospitals, the hospital administration usually assumes the rental cost of the equipment necessary to establish the network. The Maryland State Health Department pays for administrative costs and the costs of preparing and distributing visual aid material. The physicians of the State of Maryland, through their parent organization, the Medical and Chirurgical Faculty, pay the cost of rental of the telephone lines establishing the links among the participating hospitals. In addition, the administrative staff of the Medical and Chirurgical Faculty acts as treasurer for the network and supplies a good deal of secretarial support.

An added feature aimed at conserving the physician's time is supplied by the administrative staff of many of the participating hospitals with the serving of lunch.

Administration: Control of the MEDIC network is the responsibility of the MEDIC Subcommittee whose parent committee is the Committee on Postgraduate Education, Preventive Medicine, and Public Health of the Medical and Chirurgical Faculty. Membership of the MEDIC Subcommittee is composed of physician representatives from each of the participating hospitals. In addition to serving on this subcommittee, these physicians handle all of the work that MEDIC creates in their hospitals. Enough cannot be said of the importance of their contributions. An advisory committee to the MEDIC Subcommittee, made up of representatives from the Medical and Chirurgical Faculty, the two Baltimore medical schools, physician representatives of the Hospital Council of Maryland and of the State Health Department, also functions. It should be noted that control of this network is, as was originally intended, in the hands of the physicians of the State of Maryland. Schematic portrayal of the administrative structure is shown in Fig 2.

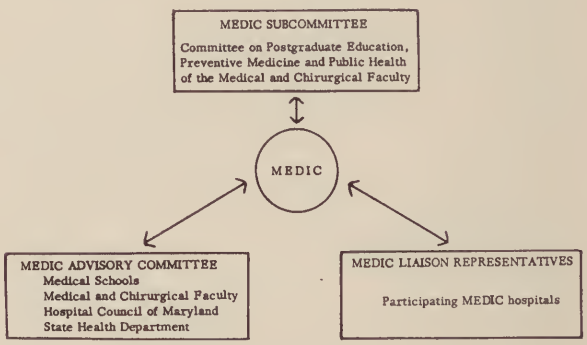


Fig 2

From the membership of the MEDIC Subcommittee, three adjunct committees have been formed: one to deal with program planning for practicing physicians; another to deal with program planning for House Officers; and yet a third to explore the varied, potential uses of the MEDIC network. Through the membership of this MEDIC Subcommittee and its various ad-

junct committees, the major part of the work involved in sustaining our educational efforts through MEDIC is being accomplished.

Programs: A week's program schedule over MEDIC is shown in Fig 3.* Up to this time, with the notable exception of the series of lectures originating from the Frederick Memorial Hospital, there has been very little master planning of program content. For the most part, the topics chosen for discussion in the Friday Lecture Series are those which seem to offer the widest interest for the medical profession. On the other hand, the series of lectures that originate on a monthly basis from the Frederick Memorial Hospital has greater direction. The entire series has a general theme. By way of example, this year it is endocrinology. Various aspects of endocrinology are explored by authorities in the field at each monthly lecture, each adding depth to the general theme.

MEDIC SCHEDULE

February 20 - 25, 1967

21st TUESDAY 11:30 - 1:00 PM - Originating from UNIVERSITY HOSPITAL
MEDICAL GRAND ROUNDS

24th FRIDAY 1:00 - 2:00 PM - Originating from FREDERICK MEMORIAL HOSPITAL
PINEAL GLAND
Dr. Richard Wurtman
National Institutes of Health

2:00 - 3:00 PM - Originating from UNIVERSITY HOSPITAL
NEUROLOGY ROUNDS

25th SATURDAY 8:00 - 9:30 AM - Originating from THE JOHNS HOPKINS HOSPITAL
PEDIATRIC GRAND ROUNDS

10:00 - 11:30 AM - Originating from THE JOHNS HOPKINS HOSPITAL
MEDICAL GRAND ROUNDS

Fig 3

Of course, little can be done about material utilized in Grand Rounds presentations. These sessions employ the use of clinical material, currently in the respective hospitals, which has appeal as "a good teaching case." In the future, with the collaboration of the two adjunct committees on program planning, it is expected that greater care will prevail in the selection of material to be used. It will be worthwhile to explore various types of programs and not to depend on the time-honored medical lecture to the exclusion of other forms of presentation. Certainly, CPCs, panel discussion, and case presentations all deserve consideration in future program planning.

Scheduling completed for the year 1967-1968 indicates that almost all of the Friday noon programs will originate from one of the community hospitals—not the medical schools. Behind this approach is the desire to stimulate active programs of continuing medical education in each hospital and to involve the local physicians in their preparation and presentation. Both the University of Maryland School of Medicine and The Johns Hopkins University School of Medicine have given their support to this concept and indicated willingness to have faculty members from each institution participate on invitation. In addition, the schools will continue to offer their Grand Rounds presentations as in the past. Thus, we will be presenting Medical and Neurology Grand Rounds from the University Hospital, and Medical and Pediatric Grand Rounds from The Johns Hopkins Hospital.

Evaluation: Evaluating the effectiveness of all efforts in continuing medical education is extremely difficult, and, at this point, no good means exists for accurate appraisal. MEDIC programs are no exception. At present, our modest attempts along these lines simply employ a tabulation of physicians attending and, hopefully, their pertinent comments and criticisms. The hospitals are supplied with evaluation sheets to be filled out for each program. A compilation of all individual reports is sent to each participating hospital. Unfortunately, however, the return of evaluation sheets for compilation has been less than 100% and the accuracy of our figures is therefore subject to question.

Timing: In addition to program content, one of the special problems to date has been the time at which the lecture programs are given. The noon hour was initially selected because this time seemed best for the majority of the physicians. However, it certainly is not optimal for all. Realization of the possible desirability of changing the time of the MEDIC lecture presentation exists; however, no time more suitable for the majority has been found. Appropriate changes should be made on the basis of experience and the will of the majority of the physicians involved. There is much that can be said for establishing a routine. In the year to come, MEDIC lectures will there-

**MEDIC programs are listed each month in* THE JOURNAL. *For those to be presented in the immediate future, see page 11.* ED.

Participating MEDIC Locations

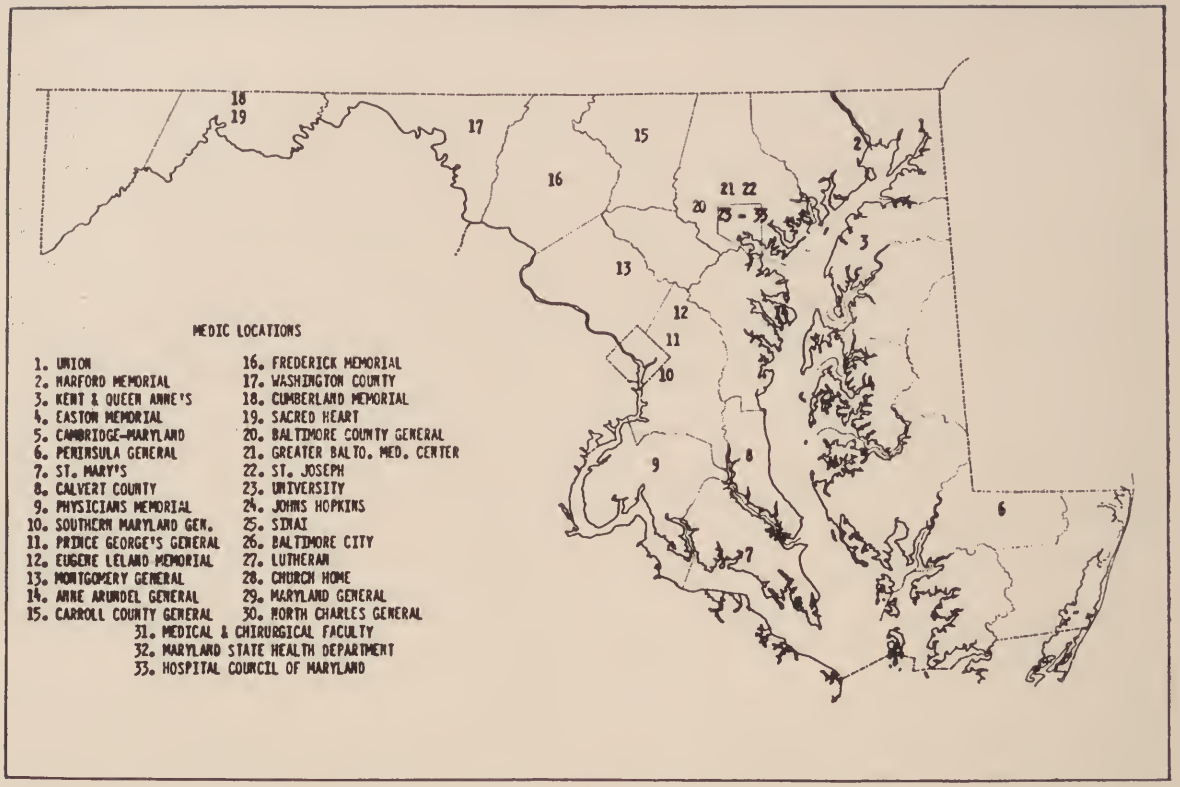


Fig 4

fore continue to be scheduled for noon on Fridays. Knowing the MEDIC schedule a year in advance may enable some physicians to adjust their own schedules accordingly.

For physicians who are unable to fit the MEDIC lecture into their Friday calendars, it was suggested that programs be taped in each participating hospital. These tapes, along with the slide material, may then be kept in the hospital for future reference by interested physicians at their leisure. The extent to which this is being carried out is unknown to us, but there is available, on loan from the Maryland State Health Department, a master tape and slide set for each of the MEDIC lectures presented so far. These tapes and slides may be borrowed by an interested physician on request.

Scope: Use of the MEDIC network may be employed by physicians in the community hospitals for their own local use. For example, by means of MEDIC, they may bring to their staff the opportunity to hear discussion of a medical point by a faculty member of either of the two medical schools in the State. By so doing, they can augment their intramural efforts and supplement their local resources. Although the prime intent of such a program would be for local use, it could also be shared with other MEDIC locations, if desired. Aside from local program planning, the only additional step necessary would be to reserve the MEDIC network for the time desired. This can be done readily by simply calling the Medical and Chirurgical Faculty or the MEDIC office at the Maryland State Health Department.

The MEDIC network represents a "hospital tool." As such, it should be available for educational usage by members of paramedical organizations: nurses, laboratory technicians, x-ray technicians, dietitians, hospital administrators, record librarians, etc. This fact has been made known to representatives of each of these groups and an invitation has been extended to them to use the MEDIC facilities for their own educational purposes. Although they have not made extensive use of the network, they have availed themselves of this opportunity on several occasions.

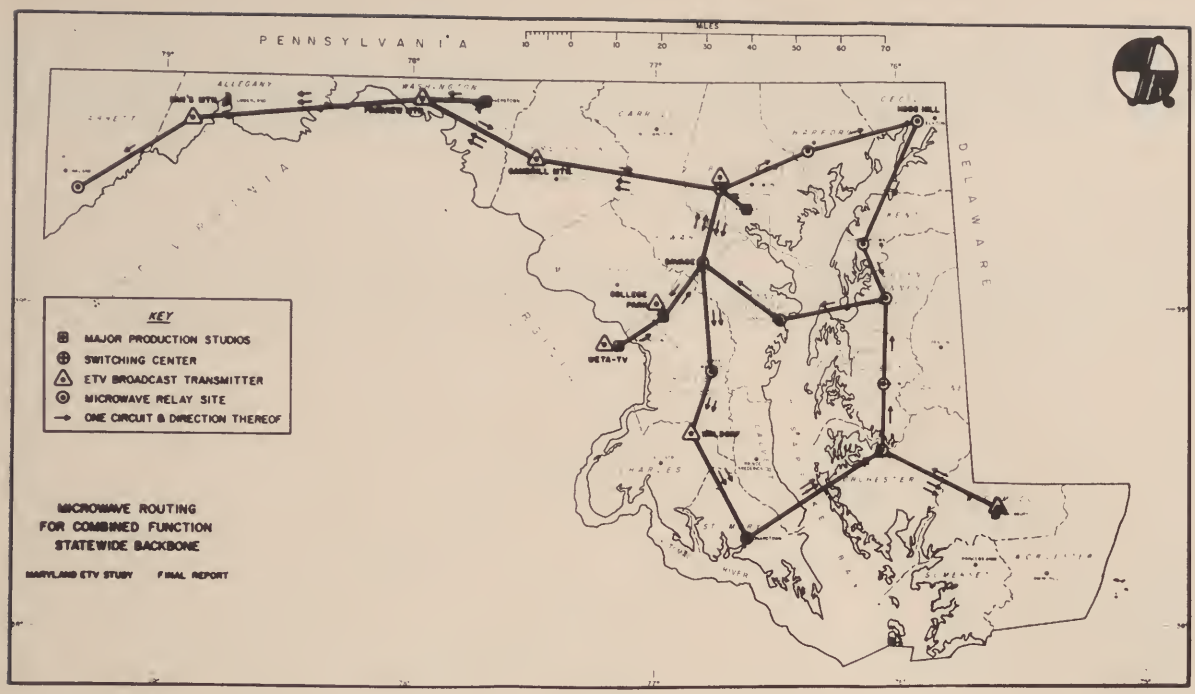


Fig 5

Growth: During the past 18 months, the MEDIC network has grown from its original membership of 12 community hospitals, plus the two medical schools, to 28 community hospitals, the two medical schools and three additional outlets: the Hospital Council of Maryland, the Medical and Chirurgical Faculty Building and the Maryland State Health Department. This represents a total enrollment of 30 of the general hospitals of the State out of a possible 44 (Fig 4). Twenty of these participating hospitals are located in the counties, and ten are located within the Baltimore metropolitan area. There remain seven hospitals within metropolitan Baltimore and seven hospitals in the counties of the State which have yet to join the MEDIC network. The hope is that they will join this venture and work to help MEDIC reach its optimum effectiveness. Provisions have also been made to add any of the Government hospitals in Maryland to the network, at their own cost, should they desire.

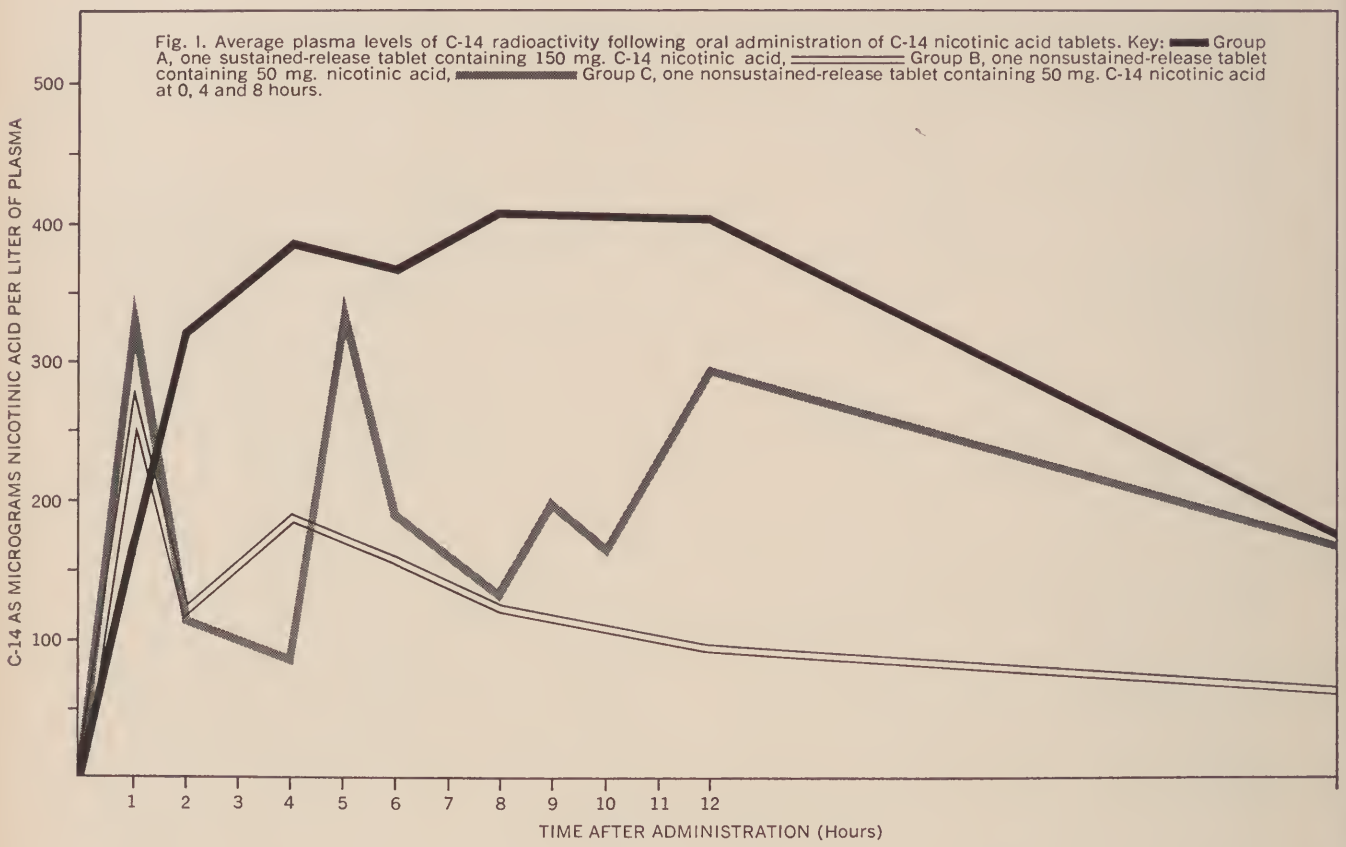
In the beginning, the original 12 community hospitals were chosen because they afforded broad coverage throughout the State. If one superimposes the locations of these 12 hospitals on the proposed lines of the educational television network for the State of Maryland (Fig 5), it becomes clear that these hospitals are situated in close proximity to them—a fact which may have potential value. It will also be noted that the 12 original hospitals are located in the counties where distance from teaching centers is a critical factor with which physicians must contend in pursuing continuing medical education. However, the goal is, and always has been, the inclusion of all hospitals in the State of Maryland within the network.

The expansion of the MEDIC network to incorporate the use of television remains a tempting plum, dangling in the future. Perhaps optimism must be tempered with realism. It should be pointed out, first, that we do not now have educational television on a statewide basis. Secondly, when and if it becomes a reality, the price will undoubtedly be high. Nonetheless, all planning for the future must certainly take into account this means of communication. While not providing a panacea, it certainly has much to offer, and in many respects it may well be superior to our present method.

It should always be remembered that continuing medical education is a personal responsibility to be met by each physician in the manner he deems most appropriate. Our hope is that MEDIC makes the task a little easier for all.

Sustained circulatory, respirator
and cerebral stimulation for th

Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▬▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.





(fewer absent doses by absent-minded patients)

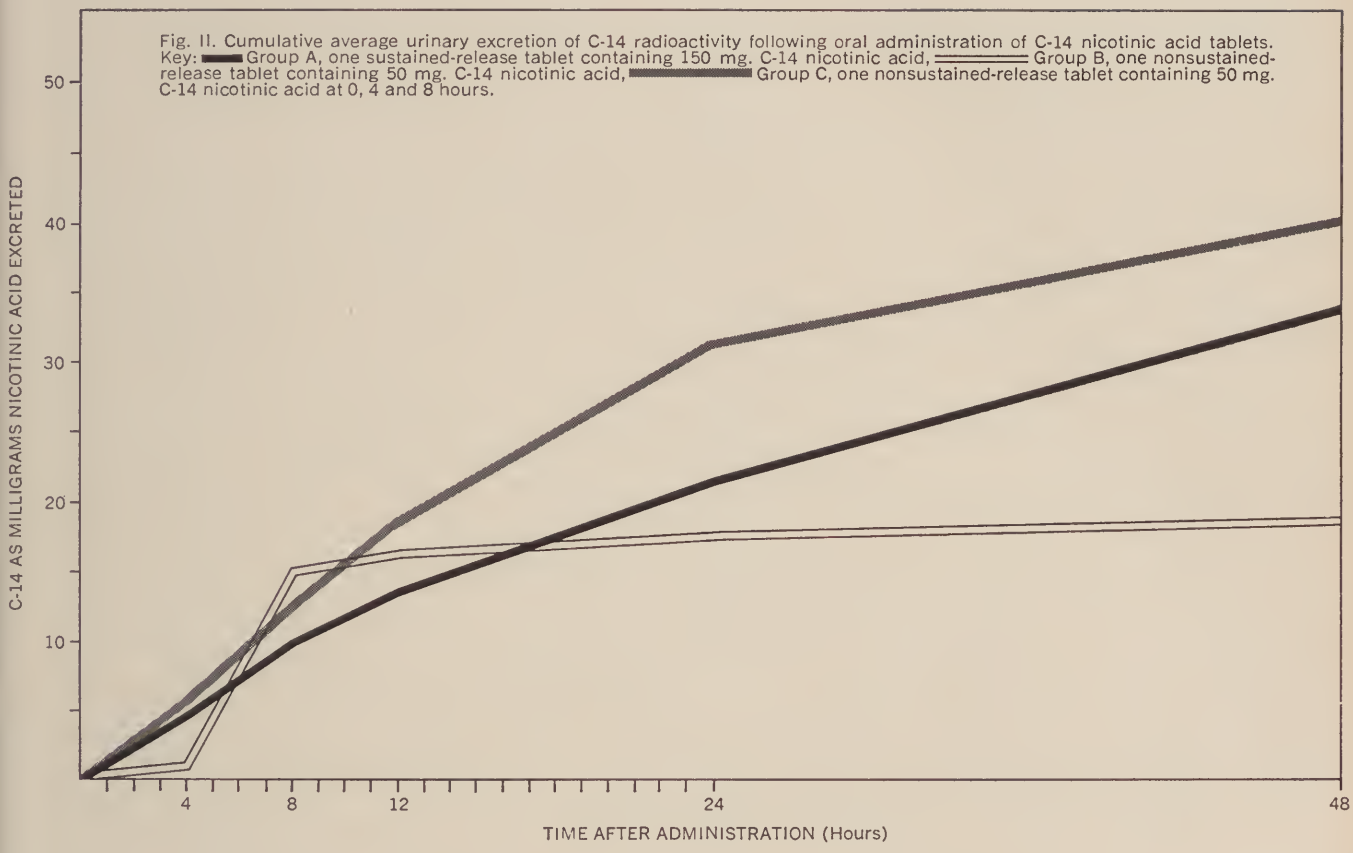
Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

ged and debilitated



less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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Hardly a staph organism can resist the bactericidal action of Prostaphlin® (sodium oxacillin), as shown by a 34-month *in vitro* study. Of all staph isolates tested, 99.5% were sensitive to oxacillin.[1]

Clinically Proven

There is a high correlation between these *in vitro* findings and clinical results. Of 610 patients treated with Prostaphlin (sodium oxacillin), 89.8% were reported cured or improved, including those with staph infections resistant to penicillin G.[2] And since resistance does not appear to develop *in vivo,* therapy with oxacillin can be extended when necessary.

Outstanding Safety Record

Besides being staph-specific and rapidly absorbed—Prostaphlin (sodium oxacillin) has established an outstanding record of safety during five years of widespread clinical use. Continuous high blood levels of oxacillin have not produced toxic effects on kidney function, assuring a significant margin of safety. However, as with all penicillins, the possibility of allergic response should be considered.

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Prostaphlin (sodium oxacillin) is available in three flexible dosage forms to suit the age of the patient and severity of infection—an oral solution for pediatric use, capsules, and multi-dose vials for injection.

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References: 1. Abstracted from *Antibiotic Sensitivity of Staphylococci Studied from November 1962 through August 1965,* reported by Griffith, L.J., Staphylococcus Reference Laboratory, V.A. Hospital, Batavia, N.Y. 2. Data on file, Bristol Laboratories.

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SODIUM OXACILLIN

A MULTIDISCIPLINARY APPROACH TO THE TREATMENT OF ALCOHOLISM

RUTH FOX, MD
Medical Director, National Council on Alcoholism, Inc.

Treatment of the alcoholic, to be successful, must be multidisciplinary. The use of psychotherapy or counseling, disulfiram (Antabuse®), Alcoholics Anonymous, group therapy, psychodrama, occasionally LSD, sometimes hypnosis, and treatment of the families concurrently will enhance the results. In many cases the clergy may also be helpful. For the social isolation of the alcoholic, and often for his employment difficulties, it will be necessary to use the many ancillary resources of the community.

Alcoholism ranks as the fourth most important public health problem in the United States; five to six million persons are afflicted with this disease. It is exceeded in importance only by heart disease, mental illness, and cancer. For every individual suffering from this disorder, there are five or six other persons related by family or business who are adversely affected. One out of every 13 male adults over 20 years of age is an alcoholic. The cost to industry is estimated to be about two billion dollars a year. There are probably nearly one-quarter of a million individuals entering the ranks of alcoholism every year.

The social consequences of this disease are incalculable. In addition to a high morbidity and mortality rate, there is a high rate of divorce, desertion, poverty, promiscuity, illegitimate pregnancies, physical abuse, and cruelty—both mental and physical. The disruption of family and social life often leads to severe maladjustment in the children and contributes to present and future delinquency, school dropouts, psychopathy, crime, neurosis, psychosis, alcoholism, inadequate personality, etc. Significantly, 52% of a large series of alcoholics had one or both parents who were alcoholic.

The stereotype of the alcoholic as a worthless derelict is incorrect; only three percent of the total alcoholic population is on skid row. Most persons suffering from alcoholism are found in homes, offices, places of business, in every walk of life without regard to social standing, occupation, intelligence, education, national origin, color, or race. A small percentage have an underlying psychosis or psychopathy, many have an underlying personality disturbance, but many are not noticeably different from the rest of us except in their addiction to alcohol. Many alcoholics after recovery prove to be gifted, talented, generous, responsible, and idealistic people, good parents and good citizens.

Since alcoholism is a complex illness with so-

Based on a paper read at the 122nd annual meeting of the American Psychiatric Association, Atlantic City, NJ, May 9-13, 1966.

Reprinted from the *Amer J of Psychiat* **123**: 769-778 (Jan 7) 1967, by permission of the editor and the author, at the suggestion of the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland.

ciological, psychological, and physical components, no one form of treatment will be suitable in every case. Since it is an addiction, with both emotional and physiological dependence, both of these aspects must be considered in treatment. The plan of therapy will vary depending on the type of individual involved.

Where alcoholism is superimposed on an underlying psychosis, treatment in a psychiatric hospital, private or public, may be necessary. For the vast majority of cases, however, treatment can be successfully carried out on an outpatient basis after a preliminary short period of "drying out" at home, in a hospital, or at an Alcoholics Anonymous rest home. Detoxification is aided enormously by tranquilizing drugs, so that these patients can now be successfully treated even in the open wards of a general hospital[1] without causing any disruption of the normal routine of the hospital. A plan of rehabilitation should be worked out before the patient leaves the hospital—a plan which can be carried out in a doctor's office, an aftercare clinic, or an outpatient department especially geared to the alcoholic.

Definition

Alcoholism is a behavioral disturbance in which the excessive drinking of alcohol interferes with the physical or mental health of the individual. It is usually accompanied by a disturbance in the interpersonal relationships within the family, in the work life, and in the social environment. It is also an addiction, which means that there is both an emotional and a physiological dependence on the drug alcohol.

Psychiatric Aspects

As an individual finds that some drive is satisfied by alcohol, he tends to repeat the experience of drinking more and more often so that drinking gradually becomes his chief source of pleasure, as well as his chief tranquilizer. He often fails to use other avenues of self-expression, may not develop the necessary skills of living through trial and error techniques, and may avoid facing and dealing with his difficulties realistically as they arise. Through constant repetition of this behavior an individual may become dependent and addicted. This can readily happen to the shy, introverted, anxious, and conflicted adolescent or young person because alcohol at first seems to solve all his problems. As his drinking increases, his performance may begin to suffer early, with consequent school dropout, poor work record, and unsatisfactory personal relationships. There is a failure of the maturation process.

A neurotic individual may find that alcohol gives him surcease from pain, obliterating or deadening feelings of inferiority, isolation, anxiety, panic, rage, anger, obsessive rumination, conflicts, depression, sexual problems, etc. Borderline or overt psychotics may also turn to alcohol and add addiction to alcohol rather quickly to their already excessive mental and emotional burdens.

But there is another group of persons, not noticeably immature, neurotic, or psychotic, who also can become alcoholic. These are the excessive social drinkers whose drinking gradually increases over the years, though it may take 10 to 15 or 20 years of this excess before the addictive process takes over. These individuals differ markedly from the immature or neurotic or psychotic alcoholics in that they have in the past used normal avenues of self-expression to which they can revert after giving up alcohol.

As the addictive process grows, all alcoholics, no matter what their background, tend to become very much alike in their behavior.[2] It is as though the disease of alcoholism molds them into a stereotyped type of reaction. Starting off with merely a mild social or psychological dependence, a physiological dependence is added—the true addictive state—with the factors of tissue tolerance, adaptive cell metabolism, withdrawal phenomena, and "craving" occurring, which leads to a loss of control over drinking.

Added to this emotional and physiological dependence, there may develop certain organic diseases such as cirrhosis of the liver, polyneuropathy, chronic brain syndrome, Korsakoff's psychosis, etc., either as a result of the toxic effect of alcohol over many years or as a result of the unhygienic way the alcoholic lives, with neglect of food and rest, frequency of accidents, etc. These diseases are not per se a part of the addictive process but are really by-products or consequences of the addiction which may cause the individual to feel so ill that recovery is often difficult.

The many psychological studies on alcoholics have failed to reveal a specific prealcoholic per-

sonality. These studies, of course, have all been done on individuals who are already addicted and may reflect the regression in the personality due to the addictive process rather than the basic character structure of the individual. During an active addiction there is no doubt that the addict is a seriously disturbed person, unable to cope with the realities of life. As the addiction increasingly controls his life, the individual's behavior becomes grossly nonadaptive. To obtain more of the drug may be the most important thing in the world, so that responsibilities toward family, job, and society no longer matter. The lying, sneaking of drinks, and the use of household money are not, however, measures of the moral integrity of the alcoholic but are rather an indication of his very great need to maintain his addiction and to prevent the almost unbearable withdrawal symptoms which are bound to occur after cessation of heavy drinking.

When sober the alcoholic feels trapped, afraid, alone, and deeply guilty—unless, of course, he is psychopathic, when anxiety replaces guilt. Convinced that he cannot live without alcohol, he builds up an elaborate defense system in which he denies that he is alcoholic and ill, rationalizes that he needs to drink for business or health or social reasons, and projects the blame for the trouble he is in on the persons nearest to him, usually the spouse or the boss. The normal longings for recognition, prestige, and love become less and less attainable as the addiction advances, so that the alcoholic feels less and less worthy, less and less secure, and less and less loved. This downward spiral is intolerable to the alcoholic, so that he resorts to drinking again unless he can get the outside help he needs.

Personality Assessment

A battery of psychological tests done on 300 consecutive private patients showed gross disturbance in each case. Though not conforming to any one personality type, these patients showed markedly similar character traits. Characteristic of them all was low frustration tolerance and an inability to endure anxiety or tension. All showed depression, with withdrawal, sense of isolation, extremely low self-esteem, sensitiveness, and a masochistic type of self-punishing behavior. Dependency strivings were very marked, frustration of which led to depression or hostility and rage. Most showed impulsive, repetitive acting out of conflicts, with little or no insight. In all cases there was a marked hostility and rebellion, conscious or unconscious, with defiance against authority figures, and almost all showed problems in the sexual area. These tests were administered after a few weeks of sobriety and represent either a fixation at an immature level or a regression to such a state. Many of these traits were markedly improved after therapy.[3]

Treatment

With such gross disturbance in the psyche, we can see that each individual will need therapy of some sort, but what kind of therapy cannot be decided upon until sobriety has been attained and a personality assessment undertaken. Psychiatrists can then use their traditional skills with marked benefit to the patient, provided they also recognize and treat the addiction itself. To analyze a patient while he is still drinking is usually a waste of the analyst's time and the patient's money—unless motivation to abstain completely is accomplished.

Psychotic alcoholics may need prolonged hospitalization, although borderline schizophrenics may often be carried successfully on an outpatient basis providing they maintain sobriety. The neurotic alcoholic may need prolonged psychotherapy, often psychoanalysis. The immature alcoholic may need support for a long time as he matures, while the individual who has become addicted in later life and has a better integrated personality may do extremely well with a minimum of therapy provided he can be convinced that he is alcoholic and can therefore never drink again. Even in these cases a few weeks or months of therapy may be needed while he is learning about his illness and adjusting to a life of sobriety.

Alcoholism has become a way of life which is no longer tenable, and therapy is largely directed toward helping the individual find a new way to live. The prevailingly negative, fearful, and hostile feeling must be replaced by a more positive attitude with hope, self-confidence, courage, a faith in himself, and a feeling of belonging.

Most patients are not motivated to stop drinking, since alcohol has given rewards they are unwilling to give up.[4] Most patients refuse to face their alcoholism for many years, using the defensive mechanisms of denial, rationalization, regression, and projection of the blame onto the

persons closest to them. When finally confronted with the threat of divorce, loss of employment, or loss of health and prestige, they may be forced to undergo therapy.

One of the most important aspects of the doctor's job is to help the patient accept his illness. This requires sympathy, tact, firmness, perseverance, but above all, respect for the individual as an ill person but a worthwhile one. He must be helped to believe that life can be more rewarding without alcohol than with it.

As with any other long-time chronic disease, relapses are to be expected early in treatment, and the doctor should show the same patience and understanding that he would if an asthma or gastric ulcer patient relapsed. A calm discussion as to why the relapse occurred can help in understanding the dynamics underlying the case. As therapy progresses the relapses will occur less frequently and will be of shorter duration. We cannot force the alcoholic to stop drinking, but we can create a climate in which he can recover.

Attention must be paid to every aspect of the patient's life and rehabilitation must be physical, psychological, social, and spiritual—a task which is too great for any one person to undertake. Since the alcoholic frequently drinks instead of eating, he is more often than not in a state of marked deficiency of essential vitamins, minerals, amino acids, and essential fatty acids. His diet must be carefully supervised, with emphasis on high protein foods.[5] It is for this reason that the team approach is often used in clinics and hospitals for alcoholics.

1. Alcoholics Anonymous

What are some of the ways to help in treating the individual patient? Of first importance is Alcoholics Anonymous, and it is good to find out at the very first meeting what the individual knows about it and how he feels about it. Though he may vehemently reject it at first, a doctor who understands AA can often correct misconceptions about the fellowship.

AA is a pragmatic, simplified, spiritual approach to life, a prescription for living. With its 12,444 chapters in 90 different countries and hundreds of thousands of recovered alcoholics, it has probably reached and helped more persons than all the rest of us together. For patients who can and will accept it, it may be the only form of therapy needed. How one refers a patient to AA is important. Just to say "You need AA" is not sufficient and may make the patient feel that you too are rejecting him. I make a personal contact with an individual member known to me, introducing the patient to him over the telephone. There can be an immediate amelioration of symptoms as the isolated alcoholic feels that there is hope for him.

It is wise for you as a doctor to keep contact with the patient even after he goes to AA, for there may still be many problems to iron out and, of course, not all persons are amenable to the AA type of experience. AA relieves the patient of the need to prove that he can drink. When in an all-drinking group he tries again and again to prove that he is not different—only to meet with failure. In AA the norm is not to drink.

Another helpful thing about AA is the fact that the patient finally accepts the need for outside help. Many of the Twelve Steps are of great value against the rationalizations and projections and denials of the alcoholic. The sharing of problems reduces anxiety and guilt, the helping of others to recover strengthens the weakened ego, and, of course, the constant examples of others who have recovered give courage and hope.[6]

2. Disulfiram (Antabuse®)

Disulfiram is another form of therapy helpful in deterring the well motivated, not too neurotic alcoholic from drinking. This is a medication given orally which interferes with the metabolism of alcohol so that even one drink will cause a toxic reaction of a shock-like nature. When not on disulfiram the alcoholic fighting the urge to drink may have to say "no" to this impulse several hundred times a day. When on disulfiram he needs to make but one decision, and that is on the taking of the pill. The effect lasts four days, which of course abolishes all impulsive drinking. Since the pill is taken every day, the ability to drink safely is well in the future. It also abolishes the preoccupation with drinking, which frees the mind for other things. Then, too, it helps the distressed family to know that the patient is even temporarily safe from alcohol. Most patients get a great lift from feeling that they *can* live without alcohol.

The dose of disulfiram is one pill (.5 gm) daily for five days, then one-half pill (.25 gm) for an

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QUINAMM Prescribing Information: Composition: Each white, beveled, compressed tablet contains: Quinine Sulfate 4 grains (250 mg.) and Aminophylline 3 grains (200 mg.). **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets. **Caution:** Federal law prohibits dispensing without prescription.

References: 1. Shumon, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rowls, W., et al.: Med. Times, 87:818, 1959.

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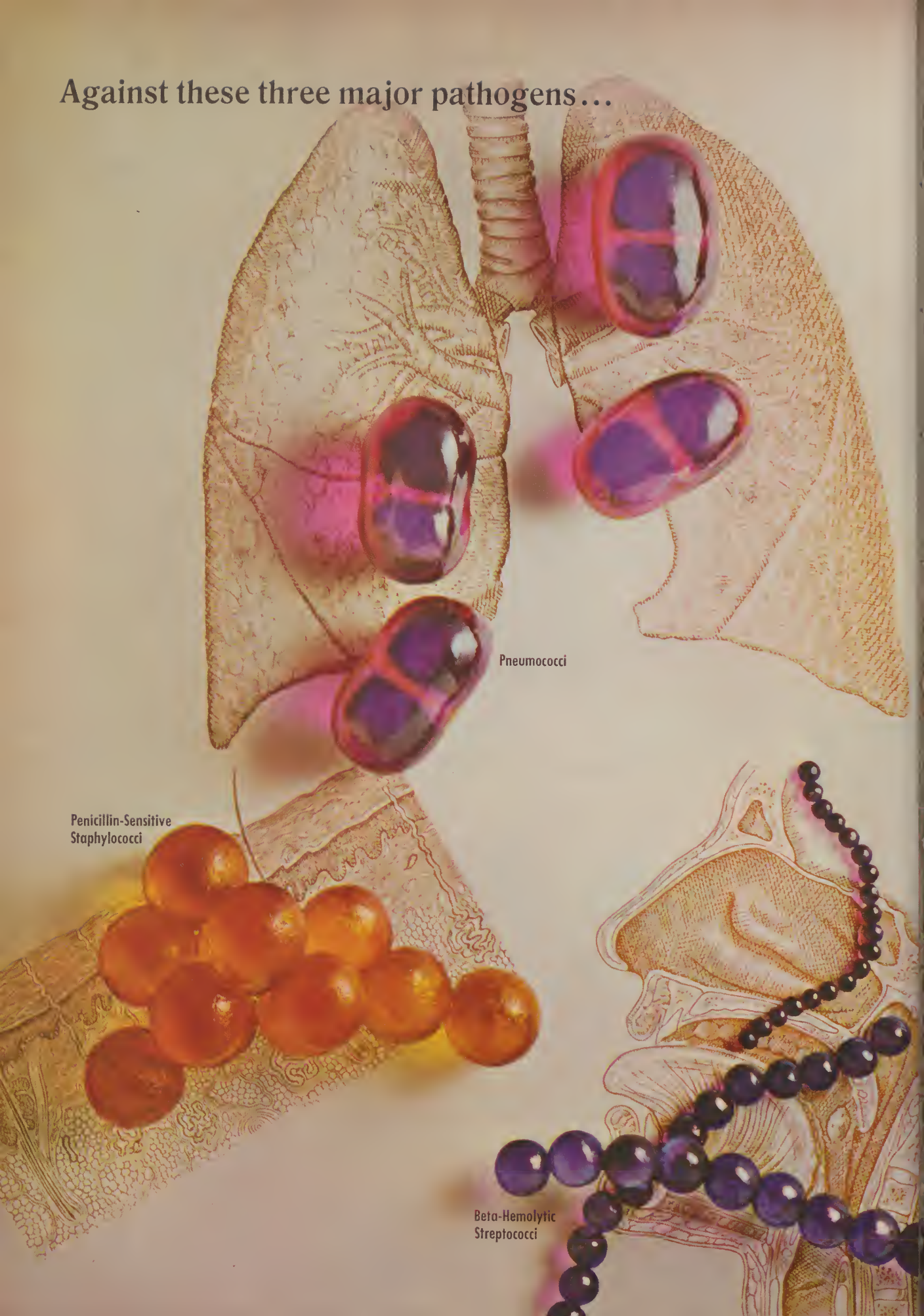
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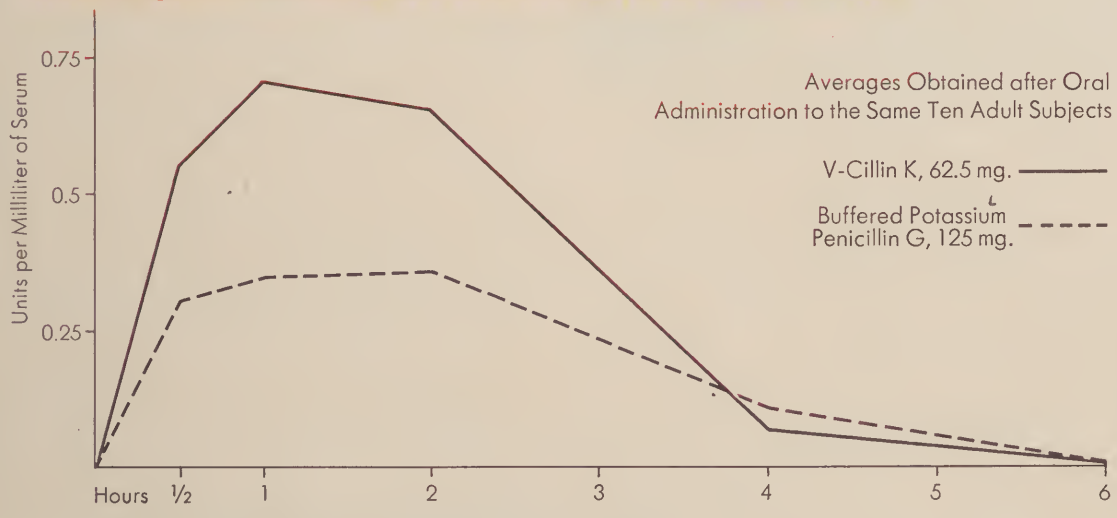
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because it combines a high degree of in-vitro activity...

Antibiotic	Staph. Aureus (Penicillin-Sensitive) MIC (mcg./ml.) Median	Range	Streptococcus, Group A MIC (mcg./ml.) Median	Range	Diplococcus Pneumoniae MIC (mcg./ml.) Median	Range
Penicillin V	0.02	0.02-0.04	0.02	0.003-0.4	0.01	0.005-0.2
Penicillin G	0.02	0.005-1.6	0.005	0.002-0.2	0.02	0.01-0.1
Methicillin	1.6	0.4-6.3	0.2	0.1-0.4	0.2	0.1-1.6
Oxacillin	0.4	0.1-3.1	0.04	0.02-0.4	0.1	0.04-0.8
Cloxacillin	0.2	0.2-0.8	0.1	0.1-0.8	—	—
Nafcillin	0.4	0.2-0.8	0.04	0.02-0.1	0.02	0.02-0.2
Ampicillin	0.2	0.1-0.8	0.02	0.01-0.04	0.02	0.01-0.04

Adapted from Klein, J. O., and Finland, M.: New England J. Med.,269 1019, 1963.

with high blood levels, even in the presence of food



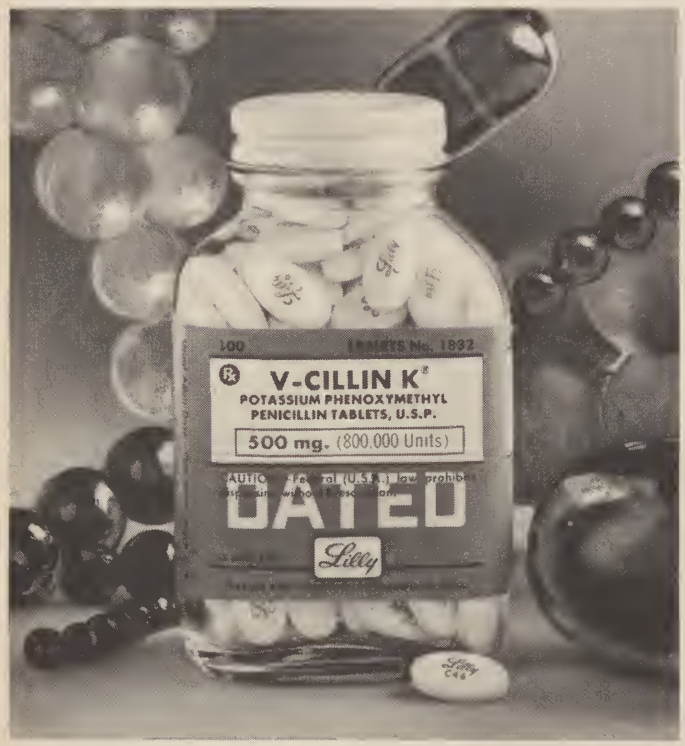
Adapted from Griffith, R. S., and Black, H. R.: Current Ther. Res., 6 253, 1964.

V-Cillin K® Lilly 7QA157

Potassium Phenoxymethyl Penicillin

(See next page for prescribing information.)

New 500 mg. tablets...a more convenient way to give high doses



Description: V-Cillin K is the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly). This chemically improved form combines acid stability with immediate solubility and rapid absorption. Higher serum levels are obtained more rapidly with this penicillin than with equal oral doses of penicillin G. The higher serum levels and acid stability of V-Cillin K make it a more dependable penicillin for oral use.

V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

Indications: V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy. Reactions occur more frequently in individuals with bronchial asthma or other allergies or in those who have previously demonstrated sensitivity to penicillin. hypersensitivity reactions occur, the drug should be discontinued.

Adverse Reactions: Although serious allergic reactions are mu less common with administration of oral penicillin than with intramus lar forms, skin rash, symptoms resembling those of serum sickness, other manifestations of penicillin allergy may occur. When penicillin administered, measures for treating anaphylaxis should be read available. Those include epinephrine, oxygen, and pressor drugs f relief of immediate allergic manifestations as well as antihistamin and corticosteroids for delayed effects.

The use of antimicrobial agents may be associated with the ov growth of antibiotic-resistant organisms; in such a case, antibiotic a ministration should be stopped and appropriate measures taken.

Administration and Dosage: For Tablets V-Cillin K and for V-Cil K, Pediatric, the usual dosage ranges from 125 mg. (200,000 unit three times a day to 500 mg. (800,000 units) every four hours. For i fants, the daily dosage may be 50 mg. per Kg. of body weight divid into three doses.

Beta-hemolytic streptococcus infections without associated bact remia may be treated with 200,000 to 400,000 units three times a da Therapy should be continued for a minimum of ten days to prevent d velopment of rheumatic fever and/or other serious complications. Do age for routine streptococcus prophylaxis in patients with a history rheumatic fever or congenital heart disease may be 200,000 units on or twice daily. When such patients undergo tonsillectomy, tooth extra tion, or other minor surgery, the prophylactic dose should be 500,0 units every six hours given two days prior to surgery and for two da postoperatively. If oral medication is not feasible on the day of su gery, parenteral therapy should be considered. Mild to moderate severe pneumococcus pneumonia has been treated effectively wi 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be giv every six to eight hours in conjunction with indicated surgical proc dures.

For gonorrhea in males, 500 mg. (800,000 units) every six hours f three doses may be employed; in females, 500 mg. every four hours f six doses are recommended. Patients with a suspected lesion of syphi should have a dark-field examination before receiving penicillin a monthly serologic tests for a minimum of three months.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units), bottles of 50 and 100; 250 mg. (400,000 units), and 500 mg. (800,0 units) in bottles of 24 and 100.

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 units) p 5 cc. of solution, in 40, 80, and 150-cc.-size packages.

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

Lilly

700

indefinite period of time. One of my patients is in excellent health after 15 years on the drug. Most patients should take it for at least two years while undergoing psychotherapy or adjusting to AA. There are no contraindications to its use except a decompensated heart or a psychosis. Disulfiram is not a dangerous drug provided the patient understands thoroughly the consequences which would ensue if he did drink and if the dosage is kept at the level suggested above.[7]

3. Psychoanalysis

Although one cannot underestimate the value of psychodynamic concepts in understanding the neurotic constitution, psychoanalysis alone as a technique has produced meager results with alcoholics. As an example I can tell you of one case, a psychoanalyst himself, whose drinking grew steadily worse during 17 years of analysis. Disulfiram, after one short slip at the end of one year, helped him attain complete and productive sobriety until his nonalcohol-connected death seven years later. After attaining sobriety he said, "I had all the *insights* I needed but I couldn't utilize them as long as I drank. Now, with sobriety, they are a great help."

I believe psychiatrists are in error in considering that alcoholism is *merely* symptomatic of an underlying personality disturbance and that treatment of the latter will cause the excessive drinking to cease. Unless the addiction itself is recognized and help given to the patient to attain sobriety, there cannot be a successful outcome. After sobriety has been attained, the patient may then be responsive to the various techniques of psychotherapy.

4. Group Therapy

Group therapy is perhaps the most effective type of treatment for the alcoholic aside from AA. There is almost immediate identification and mutual support, which makes the alcoholic feel immediately accepted. The group represents a nonthreatening, socially rewarding yet challenging atmosphere in which their many problems can be discussed. Problems about drinking, their jobs, and their families come up first, but soon they begin to discuss and show their deeper feelings of anger, resentment, sensitivity, guilt, distrust, loneliness, depression, fear, sense of inferiority, and worthlessness. When met with the sympathetic warmth and understanding tolerance of the group, many of these painful feelings are drained off.

The various interactions between members of the group, both negative and positive, give a chance for analysis of typical modes of reaction in the outside world, many of which are found to be of an irrational or transference variety. Typical maneuvers or defenses, such as denial, rationalization and projection become evident and are discussed in nontheoretical terms. Many strong and lasting friendships grow up in the group.[8]

Group therapy of the spouses of alcoholics has also been found to be of great help. Several studies of the wives of alcoholics have shown them often to be greatly disturbed individuals. Some of their neurotic traits antedated the marriage, but many are a direct result of the crisis of living with an alcoholic. The organization called Al-Anon Family Groups, an off-shoot of AA, is a fellowship for the family members of the alcoholic and has proved extremely helpful, as has Alateen for the teen-age children of alcoholics. So many spouses have become bitter, lonely, vindictive, and punishing—attitudes which militate against recovery of the sick alcoholic. Many times the wife has to be helped to cease overprotecting the alcoholic, for he must eventually learn to accept the consequences of his actions.[9]

5. Psychodrama

Psychodrama has been found to be especially effective for many patients.[10] One individual is picked or picks himself to be the star or the protagonist of the evening. He soliloquizes first about some problem of the past, present, or future until a scene evolves, with other patients playing the roles of significant others—the wife or husband, boss, parent, child, or friend. Psychodrama requires direction by an especially trained psychodramatist* able to use the various techniques such as auxiliary ego, doubling, or role reversal, all of which help to clarify the true underlying feelings.

It has been found that patients reach a high level of emotional involvement rather quickly in psychodrama. One short example may serve to illustrate what can happen. One patient, a middle-

*All of my sessions were conducted by Miss Hannah Weiner of Brooklyn, NY.

DIARRHEA



CANTIL®
(mepenzolate bromide)

Diarrhea, one of the most vexing symptoms of common G. I. disorders can often be curbed with Cantil (mepenzolate bromide), bringing welcome relief to the harassed patient. Relatively specific for the hyperactive colon, it helps reduce diarrhea, pain and spasm with minimal effect on other viscera. Cantil (mepenzolate bromide) is indicated whenever these symptoms are associated with irritable colon, gastroenteritis, diverticulitis, and mild to moderate ulcerative colitis.

It is an anticholinergic drug without narcotic properties. Side effects are usually mild.

LAKESIDE

IN BRIEF: One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth, blurring of vision, constipation, nausea, vomiting, bloating and dizziness may occur but are usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy — withhold in glaucoma. Contraindicated in patients sensitive to phenobarbital and/or Cantil (mepenzolate bromide); in toxic megacolon, obstruction of G. I. or G. U. tract.

SUPPLIED: CANTIL (mepenzolate bromide) — 25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL — containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

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aged social worker, had lost his job through drinking and went into a deep depression. After a few weeks of nonparticipation in the group, the patient began to talk about the time his drinking became excessive. This was immediately following the unexplained death of his son in college; it had never been clear whether this was a suicide or not. Another younger patient immediately went over and sat down by his side, playing the role of the now dead son. The younger man insisted that his death had been due to a heart attack and was not suicide. He further showed that he had had great love for his father and admired him greatly.

Role reversal was needed, with a recall of many things the two had done together. This gave an opportunity for the younger man, who had been fighting with his father all of his life, to become friendly with an older man and say many of the things he had never been able to say in reality to his own father. The older man was able to give up many of his guilt feelings as he related affectionately to his "son." This little psychodrama helped jar both persons out of their frozen, nonadaptive roles and helped initiate a recovery in both which has been maintained for years.

6. Lysergic Acid Diethylamide

Although my experience with lysergic acid diethylamide (LSD) in alcoholism has been limited to only 20 severe, recalcitrant alcoholic cases, the results are sufficiently promising to lead me to hope that it can be studied with much larger groups. Extensive studies have been made on alcoholics by Dr. Abram Hoffer[11] of the University Hospital in Saskatoon, Saskatchewan, Canada, and Dr. Keith Ditman[12] of the Alcoholism Research Clinic at the University of California Medical Center in Los Angeles, with claims of marked improvement in a sizable proportion of alcoholic patients.

My final impression on a three-year follow-up of the 16 patients (out of 20) who showed improvement was that LSD was but one of the factors which helped in their very considerable over-all improvement. It does seem that LSD, by breaking down the barriers between the conscious and the unconscious mind and by uncovering early traumatic events in their lives, allows the patients to reassess and reevaluate many of their experiences. Many get a new concept of themselves and others, giving up many of their rigid defenses in favor of a more open and optimistic view. LSD does seem to make the patient more willing to undertake the total program necessary for his recovery. After LSD most of the patients who formerly had refused to cooperate were willing to take disulfiram, attend group therapy and psychodrama, and to affiliate with AA. Those who at the same time were undergoing an analytic form of therapy seemed to make more rapid progress.[13]

One disturbed young man who had blamed his "cruel" parents for his drinking, and who had refused to speak to them for ten years, had flashbacks of memories from early life of his parents taking him and his brother swimming, fishing, to the circus, etc. He realized that he had been loved by them and felt flooded with affection and understanding for them. One week after LSD he went to see them and the following summer took them on a vacation to Ireland. They are still good friends, and the abstinence attained is still present after four years.

It cannot be overstressed that a patient undergoing LSD treatment must not be left alone for at least eight to ten hours while under the drug and must be given constant support during the treatment. Several individual sessions after the LSD must be held in order to integrate the material uncovered into the total therapy program.

7. Aversion Treatment

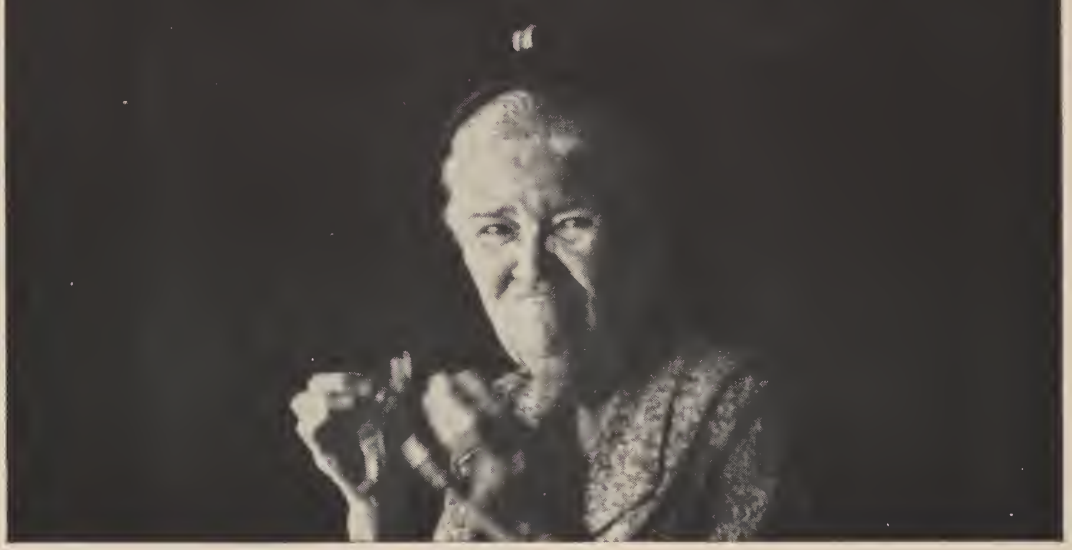
Aversion treatment of alcoholism still continues in a few places in the United States and more generally in England and Russia. Aversion can be produced chemically by giving the patient emetine or apomorphine,[14, 15] which produces vomiting within seven to eight minutes. One or two minutes preceding the vomiting the patient is given many types of alcoholic drinks, which he vomits. He then associates the sight, smell, and taste of alcohol with vomiting. This aversion to alcohol in some cases may last for many years.

A new type of conditioning is being carried out in a few places using succinylcholine. This preparation causes muscle paralysis so that the patient is unable to breathe for 30 to 40 seconds. Just preceding this he smells and tastes alcohol. The paralysis of breathing is associated with profound fear, which is then associated with drinking.[16, 17]

Other techniques using learning theories are

IRON DEFICIENCY

ANEMIA



Imferon®
(iron dextran injection)

There's as much iron . . . 250 mg. . . . in a 5 cc. ampul of Imferon (iron dextran injection) as in a pint of whole blood. When iron deficient patients are intolerant of oral iron . . . or orally administered iron proves ineffective or impractical . . . or if the patient cannot be relied upon to take oral iron as prescribed, Imferon (iron dextran injection) dependably increases hemoglobin and rapidly replenishes iron reserves. Precise dosage is easily calculated.

LAKESIDE

IN BRIEF: ACTION AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion as a source of iron; infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

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under investigation by the behavior therapists. One of these is the use of moderately painful electrical stimulation to the hands or head at the time of drinking. Treatment by reciprocal inhibition also shows promise.[18]

8. Hypnosis and/or Relaxation

Although I believe that teaching a tense, nervous person to relax is of great value and will often improve his sleep pattern, I doubt whether the compulsion to drink is much influenced by either relaxation exercises or hypnosis. The good results may well be placebo effects which may or may not be lasting, depending on the *total* therapy situation. If the alcoholic really wishes to drink, he will either resist going into a trance or will subsequently resist the post-hypnotic suggestion of not drinking. If he does wish to stop, suggestions to reinforce this determination will surely help, but this may be done about as well at the conscious level as under hypnosis.

However, Dr. Lincoln Williams, who has had extensive experience using hypnosis as an adjunct to psychotherapy in alcoholic patients, states that if patients can achieve a really deep trance, suggestions that they will henceforth be indifferent to alcohol may be partly successful. He sees the patients daily for ten days and teaches them auto-hypnosis. He stresses the fact that this is only an adjunct to psychotherapy.[19]

A report has just appeared in which a well-controlled study of 40 patients carried out at the Maudsley Hospital, London, failed to show any greater improvement in the 20 who were given hypnotic suggestions than in the 20 who were not. All patients were given disulfiram and attended AA. All received individual psychotherapy, and social rehabilitation and social casework were available to all as required.[20]

Probably further work must be done in this field before we discard hypnosis entirely as an effective adjunct. Perhaps the depth of trance is important, as well as the personality of the therapist and the expectation of the patient.

9. Treatment of Families

Treatment of the families of alcoholics has been found to help greatly in the recovery of the patient. By early detection and successful treatment, many social ills can be greatly ameliorated, for alcoholism ranks high as a contributing cause in many disturbances of children and adolescents. Having often come from a disturbed family background himself, the alcoholic "disturbs" his own family, so that he helps to pass on a neurotic heritage—a kind of "social contagion." Probably no family in which there is an alcoholic can be considered a happy one. In spite of a brave front, the lives of many are being insidiously and painfully wrecked beyond any possibility of future mental health.[21]

The wife of an alcoholic may seem on the surface to be just an innocent victim of her husband's drinking, but a number of studies have shown her to be often almost as neurotically ill as her husband.[22] Many are insecure persons who picked their mates to satisfy some neurotic needs of their own and in their disappointment and frustration at the husband's irresponsibility and general inadequacy retaliate by an active or passive type of punishment which renders the husband all the more inadequate and drives him inevitably into further and deeper drinking. Some of the neurotic needs of such a wife may be to be dependent, to control, to dominate, to punish, or to be the long-suffering martyr—character traits which make such a woman not only a poor wife but generally a poor mother as well.

Indeed, sometimes her effect on her children may be more destructive than that of their drinking father. If she is unable to love, this may be even more detrimental to her child's development than her husband's inability to remain sober. Of course, many of the wives were quite normal persons before the alcoholism developed but have become frightened, frustrated, angry, and extremely disturbed due to the ever-recurring crises in an alcoholic family.[23]

These women are badly in need of help and understanding of themselves as well as their husbands. They may need to learn in what way they may be interfering with their husbands' recovery. A wife is not responsible for her husband's being alcoholic, of course, for this is his own illness, but she may be totally unaware that her reaction to his behavior is actually making the situation worse. Group therapy for her own neurotic problems, or Al-Anon,[9] or both, may give her the insights she needs to help him recover. Alateen is proving of great help to the children of alcoholics.

DIURESIS



MERCUHYDRIN®
(meralluride injection)

Twenty years ago the publication of "A System for the Routine Treatment of the Failing Heart"[1] established a schedule of diuretic therapy as a primary factor in the treatment of acute congestive failure. With emphasis upon daily injections of Mercuhydrin (meralluride injection) until dry weight was obtained, Gold, et al. achieved a 40% increase in improvement, in ⅓ the time, over other methods then current. Today, most medical texts continue to recommend parenteral mercurials in acute congestive failure when prompt diuresis is indicated.

Recently Modell[2] has stated: "The mercurial diuretics are the injectable diuretics of choice since they are the most potent as well as the most dependable. Their toxicity is not an important consideration either by comparison with other potent diuretics or in relation to the seriousness of the conditions in which they provide such excellent relief."

LAKESIDE

IN BRIEF

Mercuhydrin is indicated in edema of cardiac or hepatic origin and in the nephrotic syndrome; it is contraindicated in acute nephritis and in anuric or oliguric states. *The usual adult dose is one to two cc. daily or every other day until "dry weight" is obtained.* Sensitivity is rare but small initial doses are advised to minimize potential reactions; vertigo, fever, and rash have occurred. Overdosage may produce electrolyte depletion, muscle cramps, and G.I. reactions. Supplied: 1 cc. and 2 cc. ampuls in boxes of 12, 25 and 100; 10 cc. rubber capped, multiple-dose vials (intramuscular or subcutaneous use only) in boxes of 6 and 100.

1. Gold, Harry, *et al.: A System for the Routine Treatment of the Failing Heart*, The American Journal of Medicine, Vol. III, No. 6:665-692 (Dec.) 1956.

2. Modell, Walter: *Drugs of Choice 1966-1967*, p. 97, 1966.

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Clergy

Clergymen have their own important and special contribution to make to the problem of alcoholism by helping in its recognition as a disease, by urging proper treatment in hospitals and clinics for the individuals involved, by supporting the families who are attempting to adjust to the problem, by accepting the alcoholic as part of the fellowship of the church, and by contributing their part to the team of workers—medical, legal, and lay—who will be necessary for the eradication of this devastating illness.[24]

Prevention

Since no disease has ever been controlled only by the treatment of the victims of the illness, efforts should be made to prevent alcoholism. This can be envisioned on three levels.

The first is the prevention of further deterioration of the person already alcoholic. The second is early case finding and special care for the population which is most vulnerable, that is, disturbed adolescents and young adults, particularly those who come from alcoholic families. Although there is no definite evidence as yet that alcoholism is inherited, it could certainly be considered contagious.

The third level of prevention will require vast changes in our cultural attitude toward alcoholism. Recognition that alcoholism is a disease and not a moral weakness will help remove the stigma which prevents so many persons from seeking help. There should be emphasis on the advisability of moderate drinking, with a de-emphasis on drinking as the only method of coping with problems or as the chief form of pleasure. This would require a change in our system of values.

Aims of Therapy

The aims of therapy of the alcoholic are not only total and complete sobriety for life but a better functioning in all areas of his life. An attempt is made to free him from his fixed and destructive role and to help him develop a greater awareness of self, a greater flexibility and adaptability, and a greater sense of his own potential. If therapy is successful there will be a growth away from the egocentricity of addiction to a social sense and an ability to relate and share with others.

Results of Treatment

Good follow-up studies of treated alcoholics have been rare until the past few years. No attempt will be made here to review this by now considerable literature, since a separate article is being prepared. "Cure" in terms of being able to go back to moderate social drinking is considered impossible by most doctors working with alcoholics, although there may be an occasional patient who can do so. Among my own approximately 3,000 patients not one has been able to achieve this, although almost every one of them has tried to. Total sobriety is usually a necessity before personality growth can occur.

Because alcoholics are an extremely heterogenous group, with very different potentials for recovery, control studies have to be set up carefully at the beginning of any research project.

In general the results of treatment of the homeless alcoholic on skid row with his weak inner resources and his poverty have been poor. Punitive measures have been totally ineffective, while newer techniques using a half-way house approach and/or the enforced giving of disulfiram by a probation officer have made it possible for many to remain sober, learn a trade, and get back into the work force—first steps in rehabilitation.[25]

Alcoholics who still live in a family setting and are still employable have a higher recovery rate. This can be shown clearly in the results obtained among the 200 or more large industries which have established programs of early case finding and treatment of their alcoholic employees. In some companies the recovery rate is 70% to 80%.[26]

Although AA keeps no statistics, they claim that of those who sincerely try to use their program, roughly one-third remain abstinent, one-third are much improved, and one-third are not improved.

One of the few well-controlled experiments was done by Dr. Robert Wallerstein in a Veterans Administration hospital. A two-year follow-up of 178 alcoholics showed that 53% of those given disulfiram plus group therapy improved; 36% of those given hypnotherapy plus group therapy improved; 26% of those given "milieu therapy" (group therapy plus individual therapy) improved; while only 24% of those given conditioned

DEPRESSION



NORPRAMIN®
(desipramine hydrochloride)

ANTIDEPRESSANT FOR RAPID IMPROVEMENT

At the recommended dosage level —initially, 150 mg. per day— gratifying remission of the signs and symptoms of depression typically begins in 2-5 days. Its specificity for depression, rapidity of action and usually mild side effects are significant reasons for prescribing NORPRAMIN (desipramine hydrochloride) In depression of any type . . . any degree of severity.

A few patients, sensitive to central nervous system stimulants may become restless as depression is lifted—in such cases dosage may be reduced or a tranquilizer added.

LAKESIDE

IN BRIEF:

INDICATIONS: In depression of any kind —neurotic and psychotic depressive reactions; manic-depressive or involutional psychotic reactions.

CONTRAINDICATIONS: Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease, epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor.

RELATIVE CONTRAINDICATIONS: (1) Patients with a history of paroxysmal tachycardia. (2) Patients receiving concomitant therapy with thyroid, anticholinergics or sympathomimetics may experience potentiation of effects of these drugs. (3) Safety in pregnancy has not been established.

PRECAUTIONS: (1) Outpatient use of desipramine hydrochloride should not be substituted for hospitalization when risk of suicide or homicide is considered grave. (2) If serious adverse effects occur, reduce dosage or alter treatment. (3) In patients with manic-depressive illness a hypomanic state may be induced. (4) Discontinue drug as soon as possible prior to elective surgery.

ADVERSE EFFECTS: Side effects, usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, anxiety, agitation and stimulation, insomnia, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, tremor, allergy, agranulocytosis, altered liver function, ataxia, and extrapyramidal signs.

DOSAGE: Optimal results are obtained at a dosage of 50 mg., t.i.d. (150 mg./day). **SUPPLIED:** NORPRAMIN (desipramine hydrochloride) tablets of 25 mg.; bottles of 50, 500 and 1000; and tablets of 50 mg., in bottles of 30, 250 and 1000.

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reflex therapy plus group therapy improved. The authors concluded that disulfiram treatment was best for the compulsive patient, conditioned reflex treatment was best for the clinically depressed patient, and group hypnotherapy was best for the passive dependent patient.[27]

I feel that successful results in treating the alcoholic depend on many factors, a few of which are the genes he is born with, the type of family which reared him, his age, his physical health, the number of years of drinking, his ability to endure stressful situations, his motivation to recover, his prealcoholic degree of adjustment, his intelligence, his education, his socioeconomic level, his living arrangements, his marital status, the cooperation or lack of it by spouse or family, his type of work, his employability, the drinking habits of his associates, etc.

Recent biochemical studies in alcoholism may help us to understand how the metabolism of these patients differs from that of normal or social drinkers. Studies on the molecular basis of memory, drives, emotions, etc, may eventually lead to a greater understanding of all human behavior—that of the alcoholic as well as that of the non-alcoholic.

Successful results may depend also on the accepting attitude of the physician he sees, his competence and his knowledge about alcoholism, his willingness to share the treatment with such groups as AA, the available resources of the community such as hospital beds, rest homes, half-way houses, trained group therapists, etc. Knowledge about local resources can be obtained by consulting the information centers of the affiliates of the National Council on Alcoholism. There are 82 such affiliates in the United States. The national headquarters of the National Council on Alcoholism are at 2 East 103rd Street, New York City.

I believe that 60% to 80% of well motivated middle and upper income patients who will undertake such a multi-disciplinary type of therapy as described above and who will pursue it faithfully for one to two years will recover. Although relapses can be expected, as in any chronic disease, these will occur less frequently and be more quickly overcome as treatment progresses.

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Vice-president: **Sidney Johnson Venable, MD**
Secretary-treasurer: **Theodore C. Patterson, MD**
Delegates to the Medical and Chirurgical Faculty House of Delegates:
Melvin B. Davis, MD
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Wilmer K. Gallagher, Jr., MD
William E. McGrath, MD
C. Herbert Mueller, Jr., MD
Policy and Planning Committee Representative:
John C. Hyle, MD



Edward Gordon Grau, MD

WASHINGTON COUNTY

The second annual Sports Seminar sponsored by the Washington County Medical Society will be held on April 1, 1967, at the South Hagerstown High School.

Registration will begin at 9:00 AM and the first paper will be presented at 10:00 AM by **Frank McCue, MD,** team physician for the University of Virginia.

Other papers to follow will be presented by **Percy Miller, MD,** of Hagerstown and **John Walmer, MD,** of Penn State.

The afternoon session will consist of a panel on training methods in football, basketball and track. A taping clinic will be conducted by the training staff of the University of Delaware.

The exhibitors will include Riddell, Rawlings, Converse, MacGregor-Brunswick, Wilson and Parke-Davis.

Luncheon will be served at the South Hagerstown High School cafeteria and will be included in the $1 registration fee.

Personal Notes

Archie R. Cohen, MD, has been named to a

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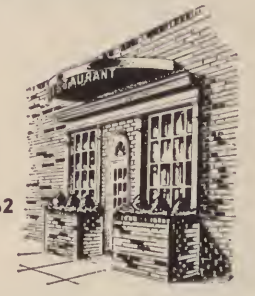
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one-year term on the Committee on Awards of the American Academy of General Practice.

In January, **Richard T. Binford, MD,** attended an allergy meeting in Boston and **Thomas V. Craig, MD,** attended a vascular surgery meeting in Florida.

In February, **John H. Hornbaker, MD,** attended a Heart Seminar at the American College of Cardiology in Washington, and **John W. Clark, MD,** attended a plastic surgery meeting in Florida.

Doctor's Day

The members of the Woman's Auxiliary to the Washington County Medical Society are planning a big party for Doctor's Day on March 30. The theme this year will be International Medicine and will be carried out in the food, dress and entertainment. Everyone is looking forward to a Happy Time.

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Alcoholism SECTION

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

AMA Action on Alcoholism as a Medical Responsibility

In December, 1966, the House of Delegates of the American Medical Association agreed that "alcoholism is a disease that merits the serious concern of all members of the health professions," and that the medical profession should provide leadership toward implementation of the historic 1956 "Report on the Hospitalization of Patients with the Diagnosis of Alcoholism."

The following five recommendations were adopted:

1. That state medical associations and component medical societies establish liaison and work with hospital medical staffs and with state and local hospital associations to implement the 1956 Statement of the Council on Mental Health;

2. That the 1956 Statement of the Council on Mental Health be resubmitted to the Joint Commission on Accreditation of Hospitals with the request that it give all possible assistance in implementing the Statement, through its publications and correspondence and through the members of its administrative and survey staff;

3. That in those hospitals which do not admit patients with the diagnosis of alcoholism the governing board, administration, and medical staff consider feasible means for providing for the admission of such patients, including, where necessary, the revision of the hospital's charter and bylaws;

4. That in those hospitals which do not admit patients with the diagnosis of alcoholism, hospital medical staffs be encouraged to review for the previous year those charts where alcoholism might have been an admitting factor. If, in fact, alcoholics are being admitted, the hospital medical staff and governing authorities should be encouraged to take a more realistic approach to the admission and handling of these patients; and

5. That insurance companies and prepayment plans be encouraged to remove unrealistic limitations on the extent of coverage afforded for the treatment of alcoholism, recognizing that alcoholism is a chronic illness and that multiple hospital admissions under medical supervision may be essential to arresting the progress of the disease.

Historic Statement

The 1956 Statement, reaffirmed ten years later by the House of Delegates, follows:

1. Alcoholic symptomatology and complications which occur in many personality disorders come within the scope of medical practice.

2. Acute alcoholic intoxication can be and often is a medical emergency. As with any other acute case, the merits of each individual case should be considered at the time of the emergency.

3. The type of alcoholic patient admitted to a general hospital should be judged on his individual merits, consideration being given to the attending physician's opinion, cooperation of the patient, and his behavior at the time of admission. The admitting doctors should then examine the patient and determine from the history and his actions whether he should be admitted or refused.

4. In order to offer house officers well-rounded training in the general hospital there should be adequate facilities available as part of a hospital program for care of alcoholics. Since the house officer in a hospital will eventually come in contact with this type of patient in practice, his training in treating this illness should come while he is a resident officer. Hospital staffs should be urged to accept these patients for treatment and co-

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operate in this program.

5. With improved means of treatment available and the changed viewpoint and attitude which places the alcoholic in the category of a sick individual, most of the problems formerly encountered in the treatment of the alcoholic in a general hospital have been greatly reduced. In any event, the individual patient should be evaluated rather than have general objection on the grounds of a diagnosis of alcoholism.

It is recognized that no general policy can be made for all hospitals. Administrators are urged to give careful consideration to the possibility of accepting such patients in the light of the newer available measures and the need for providing facilities for treating these patients. In order to render a service to the community, provision should be made for such patients who cooperate and who wish such care.

In orded to accomplish any degree of success with the problem of alcoholism, it is necessary that educational programs be enlarged, methods of case finding and follow-up be ascertained, research be encouraged, and general education toward acceptance of these sick people be emphasized. The hospital and its administration occupy a unique position in the community which allows them great opportunities to contribute to the accomplishment of this purpose. It is urged that general hospitals and their administrators and staffs give thought to meeting this responsibility.



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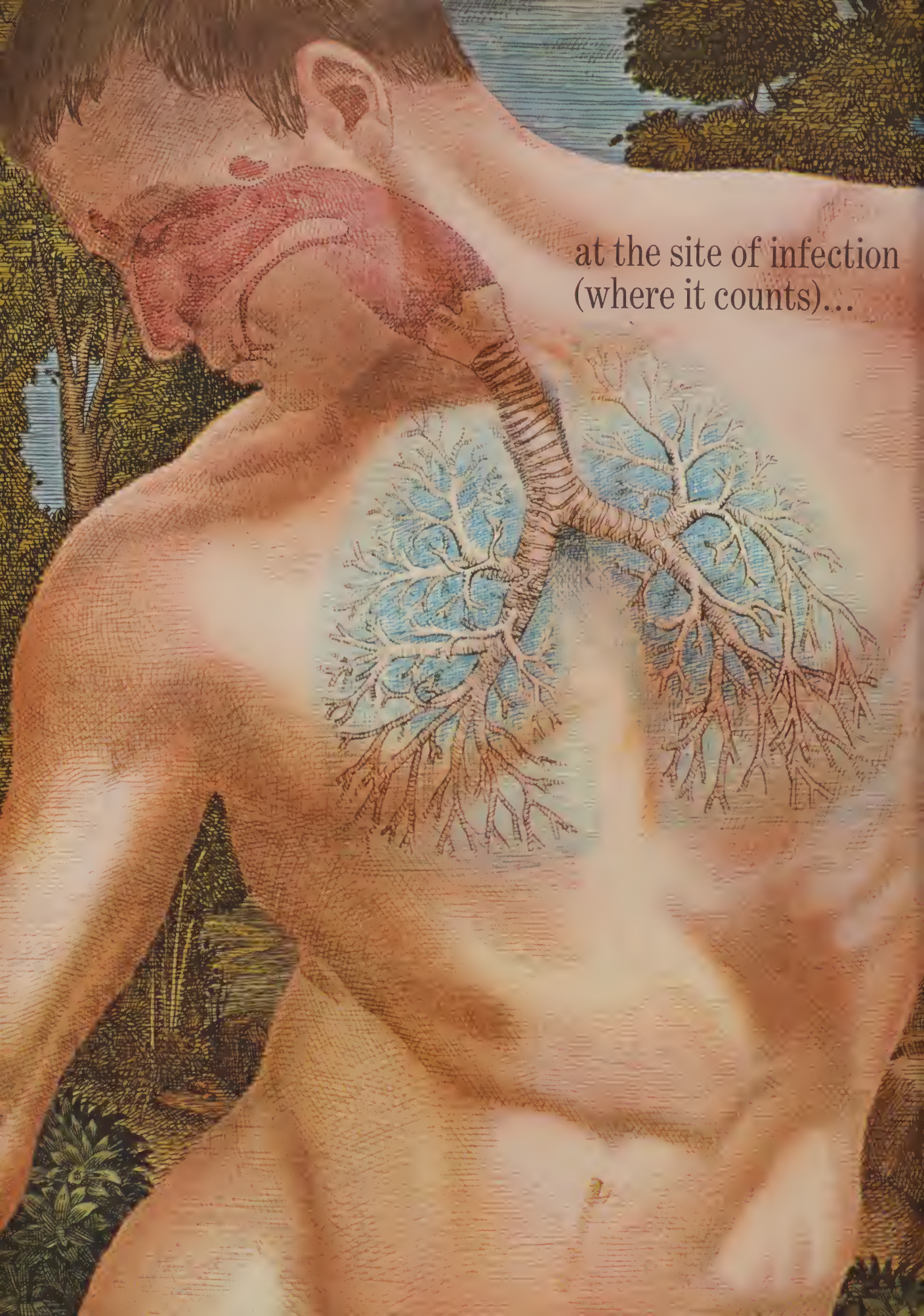
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Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

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Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Side-Effects: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have appeared in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly if the drug is readministered to sensitive patients, usually within forty-eight hours. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appeared to be definitely related to use of the drug, laboratory findings we characterized by increased direct-reacting bilirubin, elevat alkaline phosphatase levels, negative or weakly positive cepha flocculation and thymol turbidity tests, elevated serum glutan oxalacetic transaminase levels, peripheral eosinophilia, and n mal cholecystograms.

Individual idiosyncrasy seems evident since jaundice has n been reported in other patients taking prolonged courses of t medication. Patients with chronic infection have been given 1 to 2 Gm. of the drug daily for periods of two to six months, a patients with rheumatic fever have taken prophylactic doses 0.5 Gm. daily for two years without difficulty. In one group 144 patients who received the drug daily for two years, no jau dice was noted. It was of interest that members of six of the patients' families, who were not taking the drug, had episod of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels we determined in a group of fifty-four adults and children who to 250 mg. of Ilosone daily for an average of sixteen months rheumatic fever prophylaxis. The results were compared wi those of a similar group of forty-four patients who received pe icillin. There were no cases of jaundice in either group. Elevati of SGPT and serum alkaline phosphatase levels during the cou of treatment was observed in one patient treated with Ilosо and in two patients treated with penicillin. Seven other patie in the group receiving Ilosone and four others in the penicil group showed elevations in one of the tests at some time duri administration of the drugs.

Very satisfactory therapeutic results, without toxicity, w reported in 102 pediatric patients who received short-term (t day) courses of Ilosone in the treatment of streptococcus inf tions. Results of liver function tests in these patients were co parable to those in a similar control group who had receiv penicillin.

Gastro-intestinal disturbances not associated with hepatic e fects are observed in a small proportion of individuals as a res of a local stimulating effect of the medication on the alimenta tract; however, the normal intestinal gram-negative bacter flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with the u of erythromycin, there have been occasional reports of urticar skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orally.

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For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythromyc therapy should be considered.

In the treatment of syphilis, the recommended total dosage 20 to 30 Gm. given in divided doses for a period of ten to fifte days. Close follow-up of the patient is necessary since erythr mycin drugs have not had adequate evaluation in all stages syphilis. Examinations of spinal fluid are recommended as pa of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four days a recommended. In the treatment of gonorrhea, patients with suspected lesion of syphilis should have a dark-field examinati before receiving antibiotics, and monthly serologic tests shou be made for a period of three months.

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REHABILITATION Notes

REHABILITATION SECTION
BALTIMORE CITY MEDICAL SOCIETY,

DOUGLAS G. CARROLL M.D.
EDITOR

Return of Upper Extremity Function in Hemiplegia

DOUGLAS G. CARROLL, MD
Chief, Physical Medicine and Rehabilitation
Baltimore City Hospitals

In previous communications, a method of testing significant function of a single upper extremity was described[1] and the findings in patients with hemiplegia were reported.[2] The present communication is concerned with serial changes in hand function over a six-month period in patients with hemiplegia.

Material and Methods

Between June 12, 1964, and June 14, 1965, 79 patients with localized cerebrovascular disease were seen in the Department of Physical Medicine and Rehabilitation at the Baltimore City Hospitals. For purposes of this study, 48 were selected on the basis of three criteria: (1) they had to have weakness of the arm and leg typical of hemiplegia; (2) the stroke had to have occurred within four months of their being first seen in the department; and (3) they had to be able to follow directions sufficiently well to perform the upper extremity test.[1, 2]

Activities of Daily Living (ADL) tests, Mental Status Check List (MSCL) scoring,[3, 4] and the Upper Extremity Function Test (UEFT) were performed on these patients. The UEFT has ben modified since the previous reports.[1, 2]

Results

Ten of the 48 patients had significant UEFT scores when first seen. Four of these had some associated speech defect at onset, but none was comatose when first seen. None had ADL scores of less than 13 when first studied. Only one patient died. The majority showed quite significant increases in ADL scores. All except one (in addition to the patient who died) showed improvement in UEFT score. Heart disease was present in only two patients.

The remaining 38 patients scored 0 on the initial UEFT. In the Table, these patients are listed in order of decreasing ADL scores,[3] and the important associated factors for each are charted. Reservations as to the exact pathological diagnosis have been commented on previously,[2] and the probable cause of the cerebral infarction is a clinical impression. The large majority of patients were thought to have had cerebrovascular thrombosis. Eighteen of the patients had some type of speech difficulty at the onset of the hemiplegia. Six were comatose on admission. All patients had suffered the hemiplegia less than 16 weeks prior to the first study. Duration of follow-up varied from two days to a year. Twelve patients died within the first six months. A number of patients showed improvement in the ADL scores, but only three showed improvement in the UEFT scores. A large number of patients had associated hypertension and arteriosclerotic heart

INITIAL FINDINGS ON 38 PATIENTS WITH HEMIPLEGIA OF LESS THAN 16 WEEKS DURATION WHO HAD AN INITIAL UEFT SCORE OF ZERO

(PATIENTS ARE LISTED IN ORDER OF DECREASING ADL SCORE)

Patient	Side	Probable Cause of CVA	Aphasia at Onset	Coma at Onset	Duration (in weeks) at First Study	Initial Scores: Age	ADL	MSCL	UEFT	Duration (in months) of Follow-up	Last ADL Score	Last UEFT Score	Associated Diseases
1. J.R.	R	T	+	0	6/7	63	100	43	0	6	100	96	HCVD
2. L.A.	L	Embolus	0	0	5/7	32	72	43	0	d.2	85	0	RHD, MS, MR
3. N.W.	R	T	0	+	5/7	44	50	26	0	2	95	0	HCVD, D
4. C.T.	R	T	+	0	6	56	45	0	0	2	100	0	O
5. R.M.	R	T	0	0	5	46	40	35	0	7	100	0	HCVD
6. B.B.	L	T	0	0	8	53	35	35	0	14	100	0	HCVD
7. B.G.	R	T	++	0	9	47	35	34	0	10	95	57	O
8. M.D.	L	T	0	0	1	68	30	39	0	2½	30	0	D
9. W.L.	L	H	0	+	8	65	28	40	0	12	95	0	HCVD
10. A.C.	L	T	0	0	1	64	25	36	0	5	70	0	O
11. E.C.	R	T	0	0	9/7	62	25	35	0	1	80	0	HCVD, ASHD
12. G.K.	R	T	0	0	3½	65	25	16	0	1	25	0	O
13. J.H.	L	T	0	0	2	55	25	50	0	4	95	0	O
14. S.B.	R	T	0	0	2	71	23	27	0	5	55	0	D
15. M.J.	R	H	++	+	7	52	20	6	0	12	70	0	HCVD, Pos. STS, CL
16. M.N.	R	T	++	0	3½	68	20	3	0	d.3	0	0	D, ASHD, AF
17. A. Be	L	H	0	0	3/7	64	20	30	0	6	70	0	HCVD
18. K.Q.	L	T	0	0	10/7	68	20	25	0	8	20	0	O
19. M.Ja	R	T	0	0	2	73	20	38	0	d.2	30	0	ASHD, MI, D
20. J.G.	L	T	0	0	5	79	20	26	0	d.2	8	0	O
21. M.M.	R	T	+	+	5/7	58	20	0	0	7	90	0	O
22. C.C.	L	T	0	0	4	79	15	19	0	8	25	0	D
23. J.McC	L	T	0	0	12	66	15	37	0	d.3	65	0	HCVD
24. J.S.	R	T	0	0	16	54	15	27	0	d.1	75	0	ASHD
25. E.T.	R	T	++	0	1	53	15	0	0	6	100	96	O
26. E.A.	L	T	0	0	12	75	15	42	0	d.4	30	0	ASHD, MI
27. M.W.	R	Embolus	++	0	2	57	13	2	0	9	53	0	RHD, MR, AF
28. V.C.	R	T	++	0	8	68	10	15	0	13	35	0	D
29. L.F.	R	T	++	0	3	77	10	0	0	d.1	10	0	ASHD
30. C.W.	L	T	+	0	1	52	10	0	0	8	100	0	ASHD, MI, AF, LH
31. H.H.	L	T	+	0	4/7	65	10	29	0	10	30	0	HCVD
32. K.C.	R	T	++	0	2/7	62	10	41	0	d.5	28	0	HCVD, D, PVI
33. E.DeM	L	T	++	0	1	62	8	13	0	d.¼	8	0	ASHD, MI
34. W.D.	R	T	+++	0	7	55	5	0	0	d.2	5	0	O
35. J.Co	R	T	+	0	1	74	5	0	0	3	5	0	O
36. R.H.	L	T	++	+	1	47	0	0	0	6	95	0	O
37. J.C.	R	T	++	0	4/7	58	0	0	0	d.½	0	0	O
38. T.W.	R	H	++	+	5/7	72	0	0	0	2	5	0	HCVD

Aphasia + = partial; ++ = severe motor; +++ = very severe

T = Thrombosis; H = Hemorrhage; d. = died

AF = Atrial Fibrillation; LH = Left-handed; HCVD = Hypertensive

D = Diabetes Mellitus; MI = Myocardial Infarction; CL = Cirrhosis of the Liver; RHD, MS, MR = Rheumatic Heart Disease with Mitral Stenosis and Regurgitation

AF = Atrial Fibrillation; ASHD = Arteriosclerotic Heart Disease; PVI = Peripheral Vascular Insufficiency

disease. Rheumatic heart disease with valvular involvement was present in two patients who were thought to have had cerebral emboli.

Examination of the Table suggests that the patients who had significant hand function when first seen were, in general, better off in total function, had fewer associated diseases, and were far more likely to show improvement in their hand function than those who had no hand function.

Further study reveals the factors which might be important in predicting which patients would improve and which would not. Most of the patients who did not improve had a zero UEFT score when first seen. Most of those who improved had some UEFT score when first seen. Moreover, those who did improve, improved greatly—reaching almost normal values. The pattern of return of function is first in grasp and pinch between the index finger and thumb. Next, function gradually returns in the fingers ulnarward to the index finger. Strength of pinch and strength of grasp tend to improve concomitantly with return in overall function.

Discussion

The pattern of recovery in hemiplegia has been described by several observers. Twitchell's report[5] is directed primarily toward neurophysiological changes. Van Buskirk[6] deals with the learning of simple tapping tasks with the hemiplegic hand during recovery. A third report[7] is concerned with recovery of motion at the joints. The present report is concerned with return of activity or function significant in the performance of daily activities.

The assumption has been made that there are certain basic function patterns of upper extremity activity that, when combined, account for most of the complex behavior available to the hand. In addition to the gross movements about the shoulder, flexion and extension of the elbow, and pronation and supination, the finer movements of the fingers can be reduced to several basic activity patterns. These hand and finger patterns are "grasp," "grip," "lateral prehension," and "pinch." To increase precision, description and scoring, these basic activities are defined in terms of the testing procedure.

About one-quarter of the patients with hemiplegia who met the criteria for inclusion in this study showed improvement in hand function during the time of follow-up. A prediction of this result can be made with a fair degree of accuracy within the first several weeks following the hemiplegia. The only patients with a zero UEFT score who showed improvement in function were seen within nine days of the onset of the hemiplegia (see Table). No patient who had been hemiplegic for more than nine days and who had a zero UEFT score showed improvement.

These findings agree with those of Bard and Hirschberg,[7] who noted that all patients who recovered full hand motion had some initial motion in the first month.

Summary

Forty-eight patients who had localized cerebrovascular disease with hemiplegia were seen in a Department of Physical Medicine and Rehabilitation within sixteen weeks of the onset. They were studied serially with a standardized upper extremity function test to ascertain the severity of impairment and degree of recovery. About a quarter of these patients showed improvement in hand function. Of the thirty-eight patients with no significant score on the test when first seen, only three recovered significant function. Of ten patients who had partial scores, only two (one of whom died) suffered deterioration during the period of follow-up. It is concluded that unless there is some evidence of hand movement and function within the first two weeks following a cerebrovascular accident with hemiplegia, it is quite unlikely that there will be return of significant function in the upper extremity. If there is beginning return of function within two weeks, it is likely that the improvement will continue.

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1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

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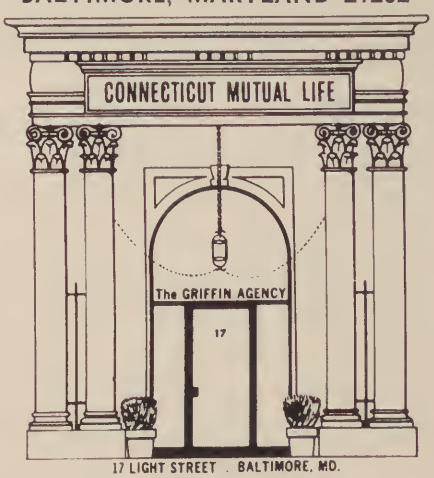
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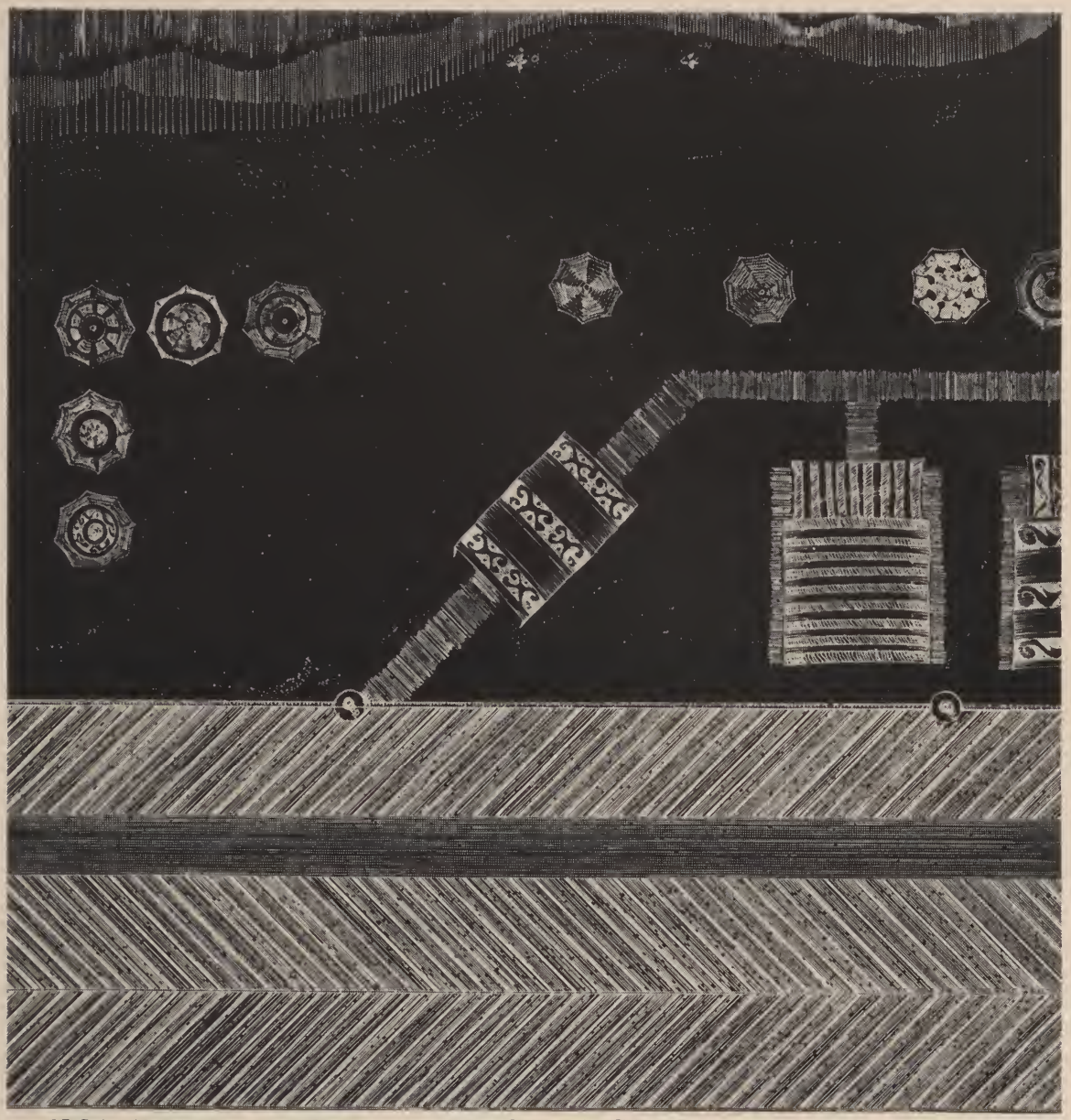
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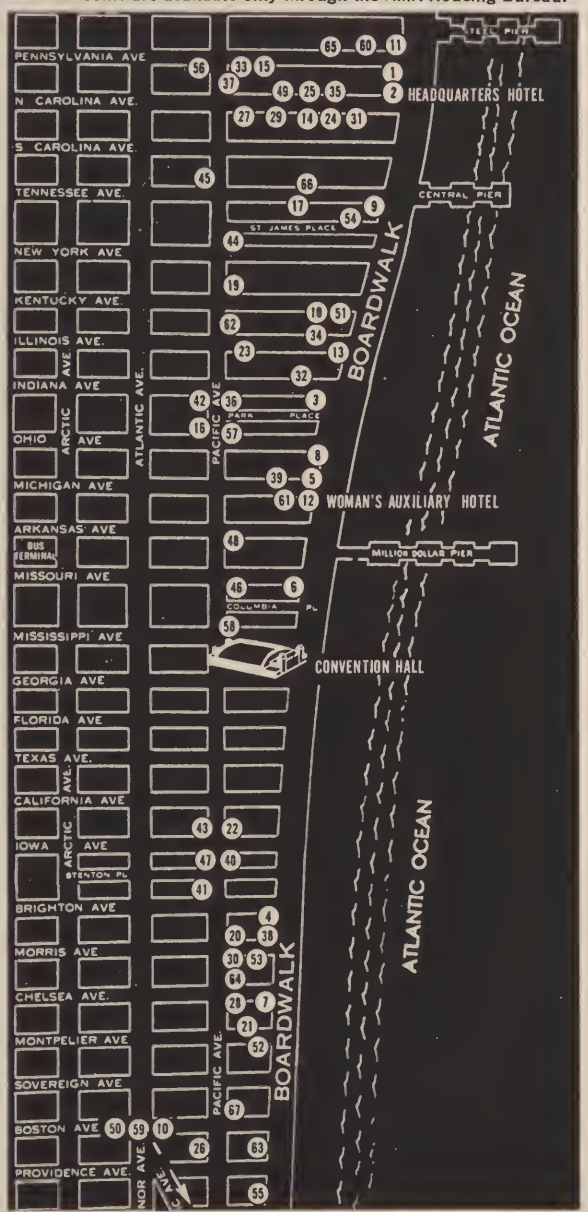
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the HEART PAGE

A Service of The Heart Association of Maryland

Elijah Saunders, MD—Editor

Coronary Care Units: Part II

LEONARD SCHERLIS, MD
Head, Division of Cardiology
JERRY SALAN, MD
Director, Coronary Care Unit
University of Maryland Hospital and School of Medicine

The constant electrocardiographic monitoring of patients who have sustained myocardial infarction has revealed that significant arrhythmias occur in 75%-80% of these patients. In one report, the incidence of premature ventricular beats was approximately 70%, ventricular tachycardia 28%, bradycardia 15%, heart block 5%, ventricular fibrillation 7.5%, and ventricular standstill 4.4%. Arrhythmias were responsible for 47% of 171 deaths in one series.

The results of intensive care for patients with myocardial infarction are now becoming available in significant numbers. In a recent summary of data obtained by the Coronary Heart Disease Section of the Heart Disease Control Branch of the US Public Health Service, it was reported that, of 1,528 patients treated in coronary care units for myocardial infarction, 180 developed cardiac arrest for a frequency of 11.8%. Fifty-nine, or 32.8%, of these arrest victims survived their hospital stay. Only the prompt recognition and treatment of cardiac arrest achieved these results. There has been little evidence, however, that any significant reduction in the number of deaths from shock has been achieved. The careful observation of patients in a coronary care unit has resulted in the philosophy that ventricular fibrillation and standstill are often preventable. It has been observed that frequent premature beats usually precede ventricular fibrillation and should be treated immediately. In the presence of myocardial infarction, ventricular ectopic beats may provoke ventricular fibrillation or ventricular tachycardia. The control of ventricular ectopic beats is therefore of fundamental importance in preventing these arrhythmias, particularly if they are frequent or occur from several foci or occur in runs. The results of prompt treatment of such arrhythmias in a coronary care unit can be most dramatic. Lown has reported only one episode of ventricular fibrillation in 201 consecutive patients with myocardial infarction. There were 26 deaths in the coronary care unit in this series. Two patients died with heart block, giving an incidence of electrical fatalities of 1.5%.

In the short history of coronary care units, certain trends are discernible. The prompt treatment of lesser arrhythmias, the earlier use of intravenous pacemakers, and the earlier diagnosis and specific treatment for failure have all changed the emphasis in a coronary care unit from the

prompt use of cardiopulmonary resuscitation measures to the prevention of cardiac arrest. The occurrence of primary cardiac arrest has been less frequent as emphasis has been placed on these preventive and earlier therapeutic measures. All patients with suspected myocardial infarction should be placed in the coronary care unit and this is especially true of the so-called "good risk" patients all of whom are still susceptible to the occurrence of sudden arrhythmias.

The major problem in establishing a coronary care unit is the availability of well trained nurses to staff the unit. There are approximately 1,200 hospitals that have 200 or more beds. It is estimated that if each of these established a five-bed coronary care unit, training would be needed for more than 14,000 professional nurses as a base figure. Similarly, 9,300 vocational or practical nurses would be required. In the 4,600 hospitals with less than 200 beds, additional trained personnel would be needed to care for patients with acute myocardial infarction in adequate care areas. As the Coronary Heart Disease Section of the Heart Disease Control Branch of the Public Health Service has stated, "Training is the most urgent need for the continued development of coronary care units in America today."

The relative roles of the nurse and of the physician will differ from unit to unit depending in part upon the availability of house staff and the training of the nurses. In some units, the nurses are able to recognize specific arrhythmias and to institute emergency measures as previously outlined by the patient's physician. This includes cardiopulmonary resuscitation, defribrillation, and the indicated medications. Where physicians are constantly on duty, the nurse will have less responsibility, but should still be taught the measures necessary in all emergencies.

It has been generally recommended that a hospital have at least 200 general care beds or 100 persons admitted per year with a diagnosis of definite or suspected myocardial infarction before having a coronary care unit. A five-bed unit with an average patient stay of seven days can accommodate approximately 200 myocardial infarction patients a year, allowing for an 80% occupancy rate.

The results of all of this planning and training should have prompt effect in reducing the mortality from myocardial infarction. However, any consideration of effective measures in reducing the mortality from arteriosclerotic heart disease must recognize that the coronary care concept, as important as it is, is only one approach to the general problem of reducing the mortality from arteriosclerotic heart disease. It is anticipated that further significant reductions can be made by the better and earlier diagnosis of arteriosclerotic heart disease, prompt hospitalization of patients suspected of acute myocardial infarction, effective cardiopulmonary resuscitation programs both inside and outside of the hospital, and—above all—primary preventive programs.

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HIGHLIGHTS

ROBERT HICKMAN RILEY, MD, DrPH

With the passing of Robert H. Riley, MD on January 25, Maryland lost a dedicated servant, famed for his contributions to public health both here and throughout the nation.

Director of the Department for 27 years, Dr. Riley's career in Maryland began in 1914 when, having received his MD and BS degrees from the University of Oklahoma, he came to Baltimore for graduate study in bacteriology and pathology at The Johns Hopkins University School of Medicine.

William H. Welch, MD, then president of the State Board of Health, soon persuaded the young scientist of the need for dedicated physicians in the public health field. His appointment as Deputy State Health Officer began a career which was to have far-reaching effects.

His assumption of the directorship of the State Health Department in 1928 coincided with his appointment to the faculty of The Johns Hopkins School of Hygiene and Public Health, where, in 1922, he had received a degree of doctor of public health.

Under Dr. Riley's leadership, Maryland gradually moved out of the "Dark Ages as far as public health was concerned" to become the first state to have a strong, locally based public health unit in each county. It also became the first state to establish a medical care program for the indigent, and one of the first to develop an extensive program for the chronically ill.

Although deprecating his own contributions, Dr. Riley felt great satisfaction as the ravages of communicable disease lessened year by year under control measures that were initiated and expanded during his tenure.

Receiving in 1953 the Arthur T. McCormick Award of the National State and Territorial Health Officers Association, Dr. Riley heard himself described as "a guide for health officers throughout the country in planning the organization and administration of medical services which have strengthened the total program of public health."

This was the man who had been born in 1880 in a log cabin near Ripley, West Virginia.

UNIVERSITY CARDIAC CLINIC RECEIVES SUPPORT

Through a contract with the University of Maryland Hospital, the Health Department has agreed to provide $50,000 annually to support the adult cardiac clinic. Diagnostic work-up, evaluation, and follow-up management will be provided on an outpatient basis, with the object of conserving hospital beds for care rather than diagnosis. The clinic will provide consultation to local health departments, advise other medical institutions on establishment of cardiac clinics, and help train personnel. The funds being used are Federal formula grant funds.

"END MEASLES" CAMPAIGN IN ST. MARY'S COUNTY

A high intensity measles vaccination campaign was carried on in St. Mary's County on February 12. Co-sponsored by the county health department

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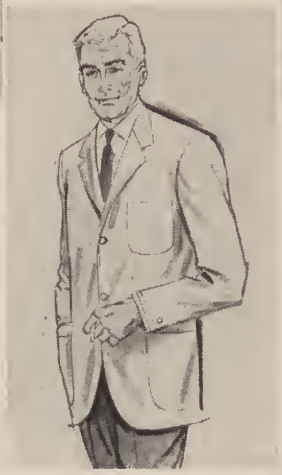
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and Medical Society, with aid from the Department's Division of Communicable Diseases, two clinics were manned by county physicians, health department personnel, and community volunteers. Susceptible children between one and twelve years received a shot of Schwarz strain measles vaccine, the cost of which was partially borne by Federal Vaccination Project funds. Parents were encouraged to make a donation to help defray costs.

PARASITOLOGY COURSE COMPLETED BY MARYLANDERS

Ten Maryland laboratory scientists, eight from the Department's Bureau of Laboratories and two from the US Public Health Service, recently successfully completed a one-year course in blood parasitology, complementing a similar course in intestinal parasitology the previous year. In all, 78 students from 35 states finished the course, which was offered by the Communicable Disease Center.

In fiscal year 1966, the State laboratories examined 6,013 specimens for intestinal parasites and 135 for blood parasites.

WEEKLY SEMINARS HELD AT BUREAU OF LABORATORIES

A series of weekly staff seminars has been inaugurated by the Bureau of Laboratories. The one-hour seminars will provide in-service instruction for Bureau and branch laboratory personnel and are open to other interested persons. Responsibility for programs rotates through the divisions —administrative, biochemistry, certification and field services, clinical laboratory services, environmental chemistry, microbiology, and virology.



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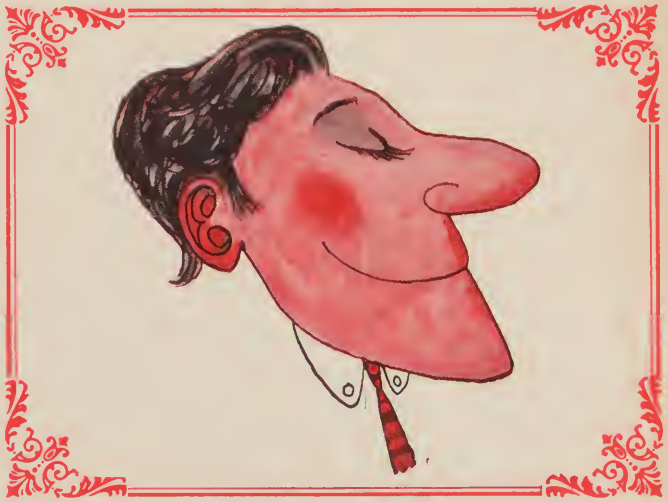
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*Brest, A. N., et al.: J. New Drugs 5:329, 1965.



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Side Effects: Dizziness, weakness, nausea, vomiting, hyperglycemia, hyperuricemia, headache, muscle cramps, postural hypotension, constipation, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin reactions, including urticaria and purpura, epigastric pain, or G.I. symptoms after prolonged administration.
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Report on Drunkenness Offenders at City Jail

The Second Annual Report on the Drunkenness Population at the Baltimore City Jail indicates a noticeable decrease in drunkenness offenders incarcerated at the City Jail during 1966 as compared with the last four months of 1965, reported in the first study. The first report covered the period from September 1965 through December of 1965. The current report is for the calendar year 1966.

A comparison of these two studies shows that for the four months of the first study there were 34,178 jail days served by 1,788 inmates. This is contrasted with a total of 57,636 jail days served by 1,970 in all of 1966.

This decline in the "Drunkenness Population" may be attributed to either or both of the following reasons:

1. More alcoholics are seeking treatment in the several State hospital Alcoholic Rehabilitation Units, through AA, in the City Health Department's Alcoholism Clinic, in Half-way Houses, or in the Municipal Court Probation Alcoholic Rehabilitation Unit.
2. Fewer arrests for *public intoxication alone* are being made. As noted previously, many persons with a drinking problem are charged with Disorderly Conduct or Disturbing the Peace.

There is still a hard core group of "revolving door alcoholics." Of the 1,970 persons in jail during 1966 for public drunkenness, 374 of them were repeaters.

The *Report* was prepared by Mr. Harry E. Shelley, Coordinator of Alcoholism Programs in the Baltimore City Health Department. Physicians who desire assistance in dealing with alcoholic patients may get in touch with Mr. Shelley by calling 752-2000, Extension 842.

Clinton L. Ewing Retires

Effective March 15, Mr. Clinton L. Ewing retired from his position as Director of the Bureau of Laboratories, a post he has held since 1933.

Mr. Ewing has served the Baltimore City Health Department and the people of Baltimore a full fifty years. Beginning in 1915 as a laboratory worker, he successively climbed the administrative ladder from assistant bacteriologist in 1917 to Director of the Bureau of Bacteriology in 1930 to Director of the Bureau of Laboratories in 1933.

Through the years he has been a visiting instructor of medical students at The Johns Hopkins University and University of Maryland medical institutions and has provided many services for the physicians and hospitals in the city. Under his guidance the Bureau of Laboratories of the Baltimore City Health Department has achieved national recognition for many innovations related to public health laboratory work, including the environmental bacteriology and chemistry of milk, food, water and air, and the control of infectious diseases.

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A Midyear Report

A total of 17,112 patients were treated in Maryland's six psychiatric hospitals during the first half of the current fiscal year. The increase of 2,876 or 20.2%, during the past five years represents a continuation of a long range upward trend. In 1962, one out of every 182 Maryland residents was under care; in the current fiscal year this figure is estimated to be one out of every 158.

This steady growth has been due mainly to the rapid patient turnover resulting from the growing number of admissions for short term intensive treatment of acute non-psychotic disturbances. As indicated in the following table, both admissions and discharges increased substantially between 1962 and 1967. At the same time, the average size of the hospital population has decreased slightly.

First Six Months of Fiscal Year	Average Size of Hospital Population	Total Patients Treated	Admissions	Discharges
1962	8,297	14,236	2,877	2,443
1967	8,010	17,112	5,305	4,946
Net Change	—287	2,876	2,428	2,503
Percent Change	—3.5%	+20.2%	+84.4%	+102.5%

The median length of hospitalization of newly admitted patients is now less than three months, and nine out of ten return to the community within one year. Only five percent remain under hospital care after two years. This has meant that there is now only a very moderate buildup in the number of patients hospitalized continuously for extended time periods. As former long term patients die or are released, they are replaced by a smaller number of new chronic cases. The net effect of this has been that:

1. The proportion of beds occupied by long term patients with chronic psychotic illnesses is decreasing while the proportion occupied by short term patients with acute psychotic and non-psychotic disturbances is rising.

2. The average period of hospitalization of newly admitted patients is going down and is now very much shorter than a few years ago. At the same time, the majority of released patients are not re-hospitalized and this proportion does not appear to be changing.

3. The average size of the hospital population is declining at the same time that the total number of patients treated is increasing. During the 1962 fiscal year there was a ratio of 2.1 patients treated for every hospital bed; in the current fiscal year this is estimated to be 2.8

The above factors have important implications. One of these is that the development of community centered programs has not as yet reduced the flow of admissions to the state hospital. Further expansion and co-ordination of alternatives to hospitalization in a state operated facility are therefore essential. It should be clear also that patient-staff ratios applicable to a custodial hospital population are not applicable to a patient population undergoing a rapid turnover. Continuing re-evaluation and reassessment of needs are therefore indicated if adequate service levels are to be maintained.

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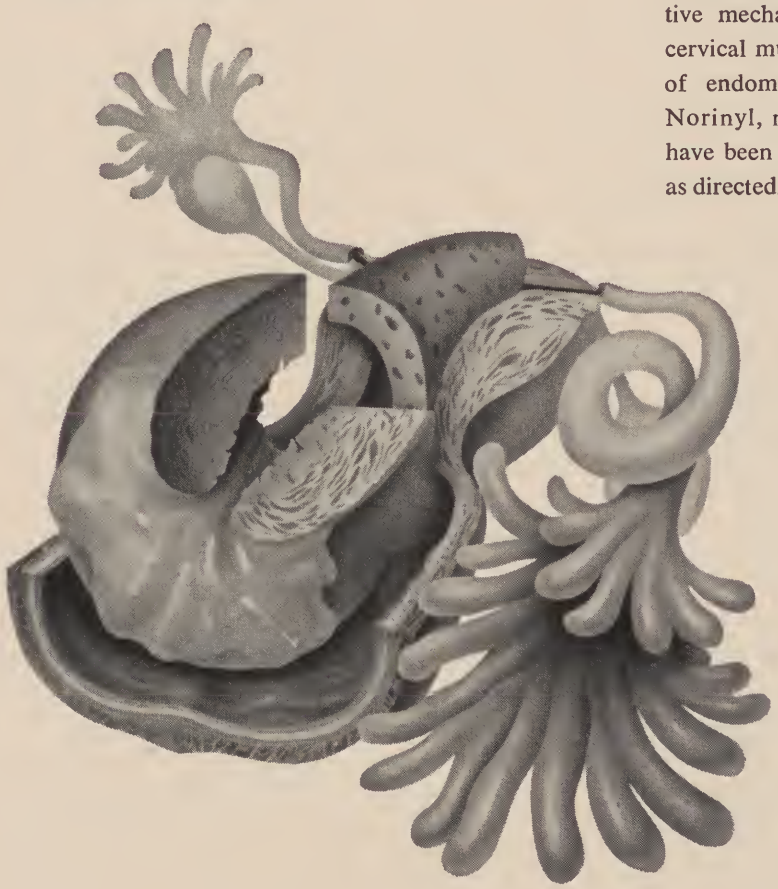
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no unplanned pregnancies

Norinyl provides multiple action for maximum assurance of success. It does not depend on ovulation inhibition alone for contraceptive effectiveness. The mechanism of action of combined hormonal therapy results in ovulation inhibition reinforced by other protective mechanisms, including a hostile cervical mucus[1-13] and an acceleration of endometrial changes.[1-3,7-16] With Norinyl, no unplanned pregnancies have been reported to date when used as directed.

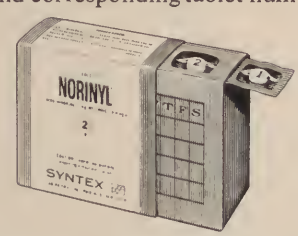
plus important supportive benefits that help her through those critical early months of oral contraception

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Contraindications: Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to confirm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.

Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism.

Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: 1. Council on Drugs. JAMA 187:664 (Feb. 29) 1964. 2. Brvans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. 3. Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. 4. Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. 5. Hammond, D. O.: Ibid. 6. Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. 7. Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. 8. Kempers, R. D.: GP 29:88 (Jan.) 1964. 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10. Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. 11. Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

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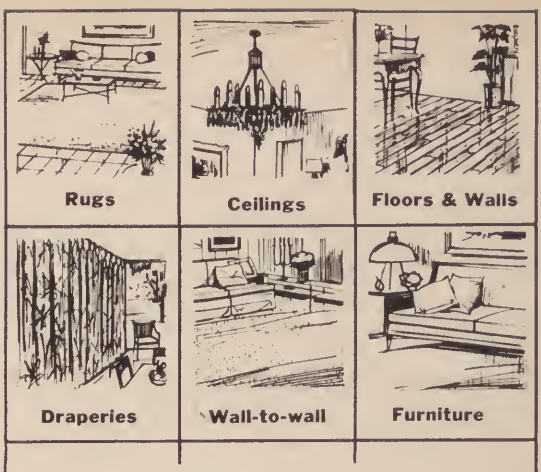
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Telephone Techniques: Part II

WILBUR L. McCLURE, JR.

Just in case you missed last month's column, it concentrated on techniques for handling "incoming" calls. The following continues the subject and concentrates on handling "outgoing" calls.

Outgoing calls to patients: "Get Betty Hernandez, please." You are referring to a patient who called prior to your arrival in the office or to a patient you must call regarding a lab report received after her last visit.

If your aide did not make a note of Mrs. Hernandez's number on the phone memo, how rapidly can she obtain it?

Once the aide has the patient on the phone, how well prepared are you to discuss and prepare notes about her case?

Acceptable answers might be as follows:

Each patient's phone number is recorded on the accounts receivable and in the office phone directory and in a conspicuous space in the medical history file. (All such phone numbers are also recorded on incoming phone memos and listed beside each patient's name on the appointment log in case it should become necessary to cancel office hours.)

Prior to lifting the receiver, the patient's medical history file is placed on my desk for review and insertion of notes. Important matters such as these are not trusted to memory or scratched on prescription pads for recording later.

Outgoing calls of a special nature: "Get the O.R. nurse at St. Agnes right away, please," or the executive secretary of the medical society, a pharmacy, an equipment supplier, a referring doctor, a laboratory, etc.

Each doctor and his aides have long lists of important numbers. The trick is to keep such a list current and available.

A few offices choose to maintain a separate telephone directory: one for patients and one for all other numbers. This is by far the best system. Generally speaking, it makes for a less cumbersome directory; and besides, if one directory is lost, all is not lost.

Outgoing calls of a personal nature: "Get my wife on the phone, please," or your stock broker, insurance representative, accountant, relative, and, in some rare cases, friends such as golf partners, club stewards, non-practice associated colleagues, etc.

The best policy here is to maintain a third directory on your desk even though an aide might have the responsibility of keeping it up-to-date.

When time permits, place all personal calls yourself. You will probably make contact much faster; furthermore, it is best to let your aide perform professional tasks.

This article and Part I should become a part of your office S.O.P. manual. Remember: That which you reduce to writing is not easily ignored or forgotten.

Mr. McClure is director of the Baltimore office of Professional Business Management, Inc. This monthly column is prepared as a complimentary service to the *Maryland State Medical Journal.*

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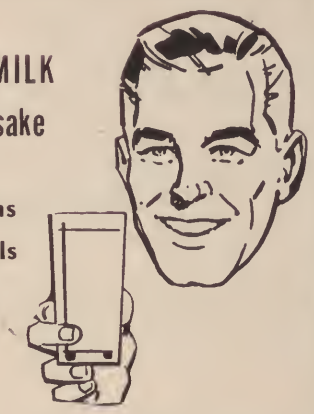
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FEBRUARY, 1967 MRS. HARRY L. BERMAN, *Editor*

Annual Meeting of the Woman's Auxiliary to the Medical and Chirurgical Faculty of Maryland to be Held April 20 in Baltimore

Wives of all members of the Medical and Chirurgical Faculty of the State of Maryland, regardless of whether or not they are members of the Woman's Auxiliary to the Faculty, are cordially invited by the Auxiliary's officers to attend the Annual Meeting to be held on Thursday, April 20, at the Sheraton-Belvedere Hotel in Baltimore. They may register either at 2 PM, Wednesday, April 19, in the Red Room on the second floor of the hotel, or at 9 AM, Thursday, on the 12th floor, where a coffee hour will precede the general session, which begins at 10 AM.

Greetings from the Faculty will be presented by E. Roderick Shipley, MD, a member of the Public Relations Committee, which serves as an advisory board to the Woman's Auxiliary. Following the business portion of the session, which will include the presentation of reports from officers and committee chairmen, and the election of officers, Mrs. Wallace H. Sadowsky, president-elect, will receive the Auxiliary gavel from Mrs. Archie R. Cohen, outgoing president.

After a sherry hour from 11:30 AM to 12:30 PM, there will be a luncheon to which members of the Faculty are also invited. It is necessary for all who wish to attend the luncheon to purchase tickets, $3.75 each, in advance. Reservations may be made through Mrs. S. G. Sullivan, 419 Oak Lane, Baltimore, Md 21204.

The theme of this year's convention is "International Health" and the principal speaker at the luncheon will be John W. Walsh, MD, of Washington, DC. Dr. Walsh, who will also speak at the Annual Meeting of the Faculty, will be returning shortly before these speaking engagements from his first voyage with the SS HOPE, which may dock in Baltimore late this year or next year as a result of the efforts of the Faculty's Public Relations Committee.

THE SYMBOL OF DOCTOR'S DAY IS THE RED CARNATION
— DON'T FORGET TO HONOR YOUR HUSBAND ON HIS DAY —
DOCTOR'S DAY — MARCH 30

Mrs. Raymond C. V. Robinson, Doctor's Day Chairman
Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland

Other speakers will include Mrs. Robert F. Beckley, Eastern Regional vice-president of the Woman's Auxiliary to the American Medical Association; J. Morris Reese, MD, president of the Faculty; Rabbi Donald N. Gluckman, of the B'nai Abraham Congregation in Hagerstown, who will give the invocation at the beginning of the program; and Mrs. Sadowsky, the incoming president of the Auxiliary, who will deliver an inaugural address.



Mrs. Robert F. Beckley, Eastern Regional vice-president of the Woman's Auxiliary to the AMA, who will address the Woman's Auxiliary to the Faculty

Mrs. Delmas D. Caples and Mrs. Martin E. Strobel are co-chairmen of the convention. They have been assisted by Mrs. William S. Stone, a past president of the Woman's Auxiliaries to the Medical and Chirurgical Faculty and the Baltimore City Medical Society, and a member of the Board of Directors of the Woman's Auxiliary to the AMA; by Mrs. Thomas S. Boyer, first vice-president of the Woman's Auxiliary to the Faculty; and by the following committee chairmen:

Mrs. David S. Clayman—Hospitality
Mrs. Max R. English—Flowers and Decorations
Mrs. Charles B. Marek—Registration
Mrs. Karl F. Mech—Credentials
Mrs. Percy H. Sutley—Exhibits
Mrs. G. Overton Himmelwright—Awards
Mrs. DeWitt E. DeLawter—Courtesy Resolutions
Mrs. A. Austin Pearre—Necrology

New Members-at-large

We welcome the following new members-at-large to the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland:

Mrs. P. J. Bean, Great Mills (St. Mary's County)
Mrs. Osman Z. Ersoy, Prince Frederick (Calvert County)
Mrs. George E. Groleau, 5204 Benson Avenue (Howard County)
Mrs. J. Roy Guyther, Mechanicsville (St. Mary's County)
Mrs. Justinas Kudirka, 40 North Rolling Road (Howard County)
Mrs. Clifford B. Lull, Braddock Heights (Frederick County)
Mrs. Lionel M. Napp, Crownsville (Anne Arundel County)
Mrs. Frank E. Shipley, Savage (Howard County)

MONTGOMERY COUNTY

The Woman's Auxiliary to the Montgomery County Medical Society held their February 21 meeting at Linden Hall Inn. Mrs. Gail H. Winslow spoke on "Investing for Profit in Today's Unsettled Market." Mrs. Winslow, an investment banker and partner of Ferris and Company, discussed the merits and methods of estate planning. An alumna of Radcliffe College, she did graduate work at the New York Institute of Finance. She has lectured extensively for years, written for

magazines and newspapers, and talked both on the radio and on television.

HARFORD COUNTY

A "baby-tender" was presented to the Harford Memorial Hospital in Havre de Grace by the Woman's Auxiliary to the Harford County Medical Society. The presentation of an article of needed equipment for the pediatric section of the hospital is an annual project of this group. A donation is also made each year to the Harford Day Care Center for Retarded Persons.

The January meeting was held in the home of Mrs. Philip Neuman where a talk and slide presentation was given by a local student, Mrs. Christine Foley of Melbourne, Australia. In February members met in the home of Mrs. Wallace Sadowsky and enjoyed an illustrated talk by Mrs. H. C. Engle on her world-wide travels.



Mrs. Wallace H. Sadowsky, past president of the Woman's Auxiliary to the Harford County Medical Society, at left, and Mrs. James Garey, president, at right, with Mrs. Theresa Green, pediatric nurse at the Harford Memorial Hospital, and small patients, one in the newly-presented "baby-tender."

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William B. Hagan, MD—1969

Terms of office expire at conclusion of annual meeting

DELEGATES TO THE
AMERICAN MEDICAL ASSOCIATION
Russell S. Fisher, MD—1966
J. Sheldon Eastlond, MD—1967
Robert vL. Campbell, MD—1968

ALTERNATES:
E. I. Baumgartner, MD—1966
Williom B. Hagan, MD—1967
Charles F. O'Donnell, MD—1968

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ACTION:
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ADMINISTRATION:
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CONTRAINDICATIONS:
Ex-Caloric Wafers are completely innocuous and may be administered with impunity in any necessary quantities to all obese patients, including children and the aged. The only contraindications are acute ulcerative colitis and organic intestinal obstruction.

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Precautions: In elderly and debilitated and in children over five, limit dosage to smallest effective amount, increasing gradually as needed and tolerated. In general, concomitant use with other psychotropics is not recommended. Paradoxical reactions have been reported in psychiatric patients and hyperactive aggressive children. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically. Observe usual precautions in presence of impaired renal or hepatic function, impending depression and suicidal tendencies.

Adverse reactions: Drowsiness, ataxia and confusion may occur, especially in elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. Syncope occurs rarely. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis, jaundice and hepatic dysfunction) may develop occasionally, making periodic blood counts and liver-function tests advisable during protracted therapy. Individual maintenance dosages should be determined.

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Maryland STATE MEDICAL JOURNAL



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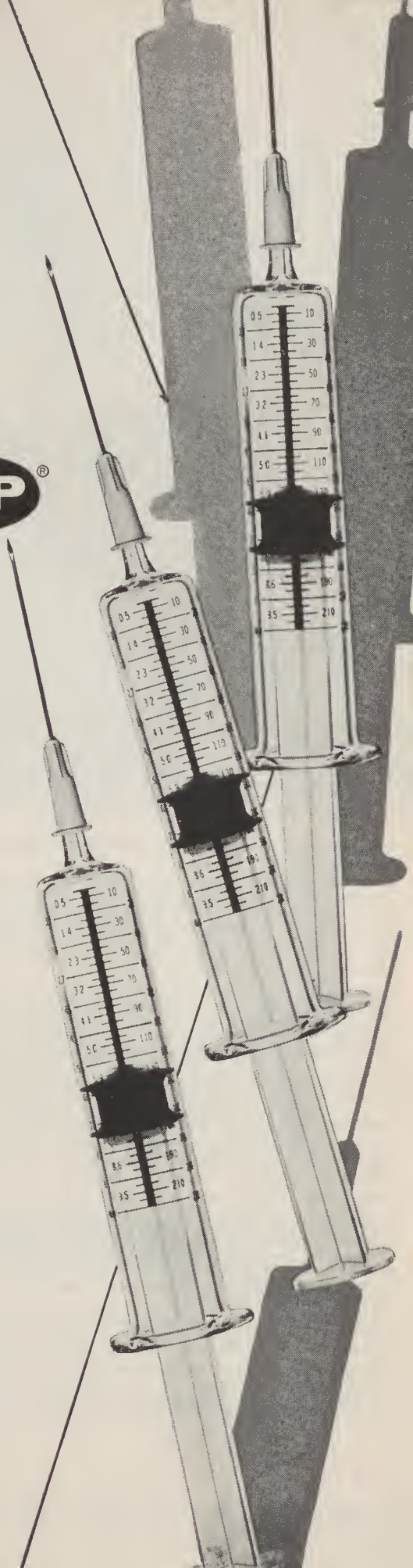

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Diagnosis:

cystitis?
pyelonephritis?
pyelitis?
urethritis?
prostatitis?

in any case,
usually gram-negative*

Therapy:

two 500 mg. Caplets® q.i.d
(initial adult dose)

Indications: Urinary tract infections caused by gram-negative and some gram-positive organisms.

Side effects: Mainly mild, transient gastrointestinal disturbances; in occasional instances, drowsiness, fatigue, pruritus, rash, urticaria, mild eosinophilia, reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), and reversible photosensitivity reactions. Marked overdosage, coupled with certain predisposing factors, has produced brief convulsions in a few patients.

Precautions: As with all new drugs, blood and liver function tests are advisable during prolonged treatment. **Pending further experience, like most chemotherapeutic agents, this drug should not be given in the first trimester of pregnancy. It must be used cautiously in patients with liver disease or severe impairment of kidney function.** Because photosensitivity reactions have occurred in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Bacterial resistance may develop.

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How supplied: Buff-colored, scored Caplets® of **500 mg. for adults,** conveniently available in bottles of 56 (sufficient for one full week of therapy) and in bottles of 1000. **250 mg. for children,** available in bottles of 56 and 1000.

References: (1) Based on 23 clinical papers, 1512 cases. Bibliography on request. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: Antimicrobial Agents and Chemotherapy—1964, Ann Arbor, American Society for Microbiology, 1965, p. 722.

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*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: E. coli, Klebsiella, Aerobacter, Proteus, Paracolon or Pseudomonas[2]... However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.

Maryland
STATE MEDICAL JOURNAL

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April, 1967

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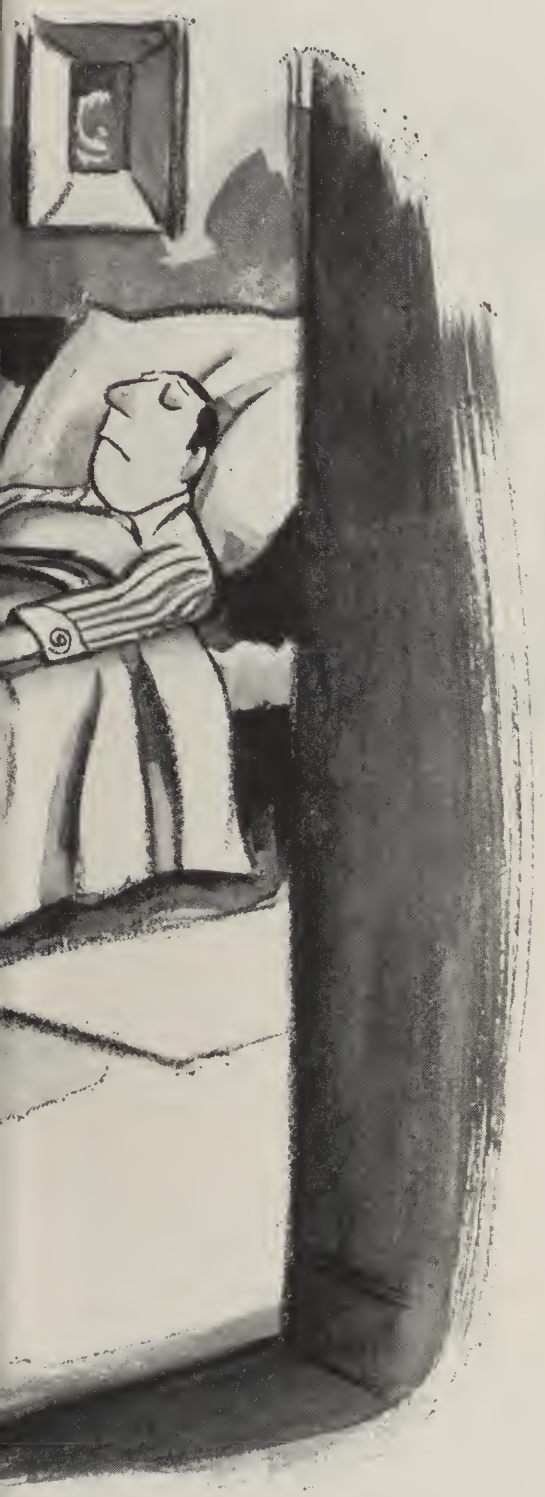
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Doctors take note...

MEDIC

FRIDAY POSTGRADUATE PROGRAMS

See page 159 for list of locations where MEDIC programs may be heard)

April 28, 1 PM

Concepts in Treatment of Adrenocortical Dysfunction

Col. William Beisel, MC, Walter Reed Unit, Fort Detrick Army Hospitol.

MAY 5, 12:30 PM

Use and Abuse of Psychotropic Agents

Gerald D. Klee, MD, Associate Professor of Psychiatry, University of Maryland School of Medicine.

and

Walter Weintraub, MD, Associate Professor of Psychiatry and Director of Inpatient Service, University of Maryland School of Medicine and Hospital.

MAY 12, 12:30 PM

Chemotherapy of Malignancy

Albert H. Owens, Jr., MD, Associate Professor of Medicine, The Johns Hopkins University School of Medicine.

MAY 19, 12:30 PM

Hypogonadism

Saul W. Rasen, MD, USPHS, National Institutes of Health, Bethesda.

MAY 26, 1 PM

Treatment of Thyrotoxicosis

J. Elliot Levi, MD, Instructor of Medicine, The Johns Hopkins School of Medicine.

GRAND ROUNDS VIA MEDIC

(The following programs may be heard at network hospitals only.)

Tuesday, April 25; May 2, 19, 16, 23, 30
11:30 AM-1:00 PM—MEDICAL GRAND ROUNDS
from University Hospital

Friday, April 28; May 5, 12, 19, 26
2:00 PM-3:00 PM—NEUROLOGY GRAND ROUNDS
from University Hospital

Saturday, April 29; May 6, 13, 20, 27
8:00 AM-9:00 AM—PEDIATRIC GRAND ROUNDS
10:00 AM-11:30 AM—MEDICAL GRAND ROUNDS
from the Johns Hopkins Hospital

MARYLAND ACADEMY OF GENERAL PRACTICE

May 20-21

Annual Spring Meeting

Washington Motel, Gaithersburg, Md

Theme: Trauma

Election of Officers

For information, write: G. O. Himmelwright, MD (president, MAGP), 133 Virginio Ave., Cumberlond, Md.

FELLOWSHIP TRAINING PROGRAMS

Comprehensive (Psychosomatic) Medicine for the Internist or General Practitioner

Applications are being accepted for training in comprehensive (psychasomatic) medicine in the Departments of Medicine and Psychiatry at the Sinai Hospital of Baltimare, a 500-bed community general hospital, closely affiliated with The Johns Hopkins University School of Medicine and Haspital. The training program is based on a 34-bed medical ward service with clinical responsibility and close supervision by staff psychiatrists and internists. Training stipends paying $10-12,000 a year are available through the USPHS. Inquiries should be directed to Bernard R. Shachet, MD, Liaison Service, Sinai Hospital of Baltimore, Belvedere and Greenspring Avenues, Baltimore, Md 21215.

116th ANNUAL AMA CONVENTION

June 18-22

Atlantic City, NJ

General Scientific Sessions on Patient Care, Backache, Healing, and Sex; **Symposia** at individual or joint meetings of the 22 Scientific Sections; **medical motion pictures**; and **live color-television programs.**

The entire Scientific Program for the 1967 Annual Convention will be published in the May 8 issue of the *Journal of the American Medical Association.*

TENTH ANNUAL JOINT CARDIAC SYMPOSIUM

April 27

Sponsored by the Heart Association of Northern Virginia, Inc., and the Washington Heart Association

Marriott Twin Bridges Motor Hotel, on US Route 1, Washington, DC

For information, write: Mrs. Anna C. Van Sickler (executive director, HANV), 609 North Edgewood St., Arlington, Va. 22201

201st ANNUAL MEETING THE MEDICAL SOCIETY OF NEW JERSEY

May 13-17

Haddon Hall, Atlantic City, NJ

No registration fee for out-of-state non-member physicians—Maryland physicians are cordially invited.
For information, write: MSNJ, P.O. Box 904, Trenton, NJ 08605.

THREE-STATE CONFERENCE ON AIR RESOURCE MANAGEMENT

May 15-16

City College New York, NY

The first attempt to develop a blueprint for community action against air pollution on an interstate basis, the conference will focus on the New York-New Jersey-Connecticut metropolitan complex. The three state health commissioners are among the members of the Conference Board, of which Norman Cousins is chairman.

For information, write: Prof. Richard G. Coulter (conference coordinator), Department of Engineering, The City College, 138th St. and Convent Ave., New York, N.Y. 10031

NINTH ANNUAL PRE-CONVENTION SESSION ON SCHOOL HEALTH

June 18, 7:30 PM

Chalfonte-Haddon Hall, Atlantic City, NJ

Mary S. Calderone, MD, executive director of the US Sex Information and Education Council, will give the principal address, and will be followed by a panel of distinguished physicians and educators, who will discuss the content of her talk.

21st ANNUAL ROCKY MOUNTAIN CANCER CONFERENCE

July 14, 15

Brown Palace-West Hotel, Denver

Symposia: "What's New in Cancer" and "Cancer of the Biliary System and its Related Structures"

Scientific papers "Information Please" Session

For information, write: Rocky Mountain Cancer Conference, 1809 East 18th Ave, Denver, Colo 80218.

AMERICAN COLLEGE OF PHYSICIANS POSTGRADUATE COURSES

The following courses are made possible by the generous cooperation of the directors and institutions involved. Tuition fees: Members, $60.00; Nonmembers, $100. Registration forms and requests for information are to be directed to: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104

May 8-12

CLINICAL AUSCULTATION OF THE HEART

Georgetown University School of Medicine and Georgetown University Hospital, Washington, DC; **W. Proctor Harvey, MD, FACP director.**

May 15-19

RECENT ADVANCES IN CLINICAL ENDOCRINOLOGY

University of Washington, Seattle, Wash; **Robert H. Williams, MD, FACP, director; Neil J. Elgee, MD, FACP, and Francis C. Wood, Jr., MD, co-directors.**

May 22-26

CLINICAL APPLICATIONS AND RECENT ADVANCES IN ELECTROPHYSIOLOGY OF THE HEART

New York University School of Medicine, and Medical Center, New York, NY; **Charles E. Kossmann, MD, FACP, director; Jacob I. Hirsch, MD, FACP, co-director.**

June 12-16

INTERNAL MEDICINE: CURRENT PHYSIOLOGICAL CONCEPTS IN DIAGNOSIS AND TREATMENT

University of Cincinnati College of Medicine, Cincinnati, Ohio; **Richard W. Vilter, MD, FACP, director.**

June 19-21

CLINICAL APPLICATIONS—RECENT ADVANCES IN PHARMACOLOGY

University of Iowa, Iowa City, Iowa; **William B. Bean, MD, FACP, director.**

AMERICAN HEART ASSOCIATION

CARDIOLOGY POSTGRADUATE COURSES

Co-sponsored by the AHA's Council on Clinical Cardiology, local AHA affiliates and medical schools

May 8-12
Cardiology Today
Atlanta

September 18-20
Congenital Heart Disease Problems
Boston

November 30-December 3
Electrocardiographic Diagnosis of Arrhythmias
St. Petersburg

Registration fee: Members and Fellows of Council on Clinical Cardiology, $50
Non-members, $85

For information, write: Director of Medical Education, American Heart Association, 44 East 23rd St., N.Y., N.Y. 10010.

CLINICAL ELECTROENCEPHALOGRAPHY

June 5-7

A second course for physicians who have had little or no formal EEG training, to be conducted in Philadelphia under the sponsorship of the EEG Society, aided by a grant from the Bureau of State Services, US Public Health Service.

For information, write: Donald W. Klass, MD, EEG Course Director, Mayo Clinic, Rochester, Minn 55901.

AMERICAN RHEUMATISM ASSOCIATION ANNUAL MEETING

June 15, 16

New York Hilton Hotel, New York City

For information, write: Miss Margaret M. Walsh, executive secretary, ARA, Section of the Arthritis Foundation, 1212 Avenue of the Americas, New York, NY 10036.

NINTH ANNUAL MEETING AMERICAN ASSOCIATION FOR THE STUDY OF HEADACHE

June 17

Colony Resort, Atlantic City, NJ

For information, write: Seymour Diamond, MD, 5214 North Western Ave, Chicago, Ill 60625.

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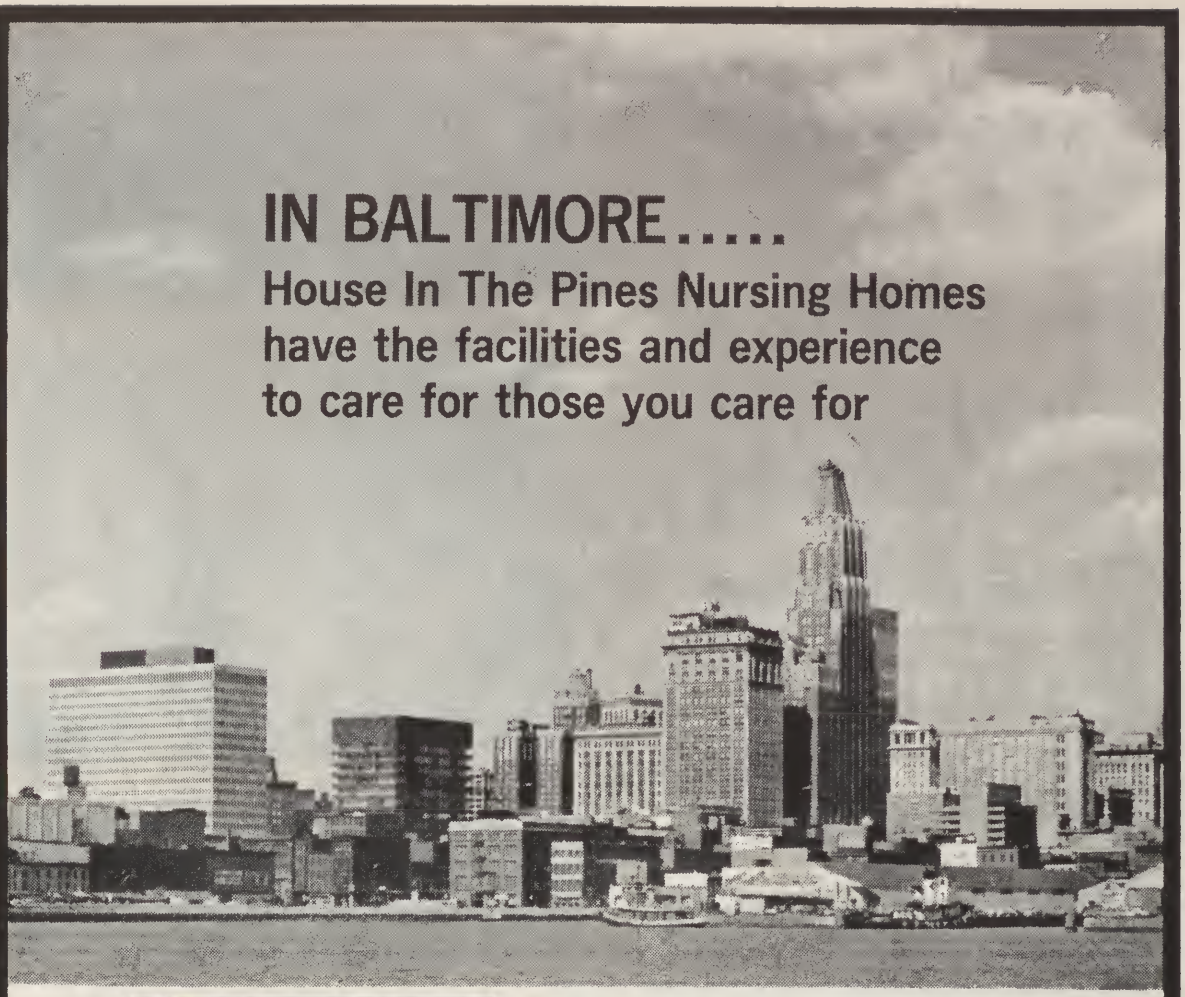
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JOHN SARGEANT EXECUTIVE SECRETARY

ON MARCH 2, THE EXECUTIVE COMMITTEE:

1. Received a revision of the Personnel Salaries Study, and deferred action until it could be analyzed.

2. Discussed Chronic Disease Hospital Admission policies with the State Health Commissioner and his aides; heard that the nursing home situation, generally, was acute and that the chronic disease hospitals had some beds closed because of a shortage of trained personnel.

3. Approved a publicity program in connection with the Mass Measles Vaccination project for which the Faculty is providing up to $15,000 for publicity and educational material.

4. Authorized a sustaining membership in the Maryland Public Health Association at a cost of $50.

5. Approved free use of Osler Hall by the State Health Department, Public Health Education Division, for morning sessions for the period of June 21 through July 10.

6. Requested legal counsel to prepare a brief and represent the Faculty at an appeal made by Leonard Flax, MD, before the AMA's Judicial Council.

7. Approved the Faculty's offering assistance in health areas in connection with the "Curlett Report," a report on reorganization of the Executive Branch of the State Government.

8. Agreed to appoint an Ad Hoc Committee to discuss educational programs for Faculty members in connection with the increase in professional liability cases against physicians.

9. Approved payment of expenses of William J. McClafferty, MD, to attend a Washington, DC, meeting on Comprehensive Health Planning.

10. Approved "in principle" the following statements, as requested by the Baltimore City Medical Society Section on Rehabilitation:

"That the Rehabilitation Section of the Baltimore City Medical Society unanimously support the State Health Department in denying certification of Extended Care Facilities unless minimum standards are met as described, under Public Law 89-97, in 'Conditions of Participation for Extended Care Facilities,' a manual published by the Department of Health, Education, and Welfare in March 1966."

"That the Rehabilitation Section of the Baltimore City Medical Society would support the State Health Department in its efforts to establish home care services for stroke patients and would provide consultative services on a fee basis to expedite this type of care."

11. Authorized the attendance of John F. Schaefer, MD, at an AMA Conference on Nursing in Chicago on October 6, 1967, with expenses being underwritten by the AMA.

12. Reaffirmed that "yellow page listings" in the telephone directory are a matter for local determination, as decided by the Council in 1964.

ON MARCH 16, THE COUNCIL:

1. Approved the Report of the Ad Hoc Com-

There are 35,700* undetected diabetics in Maryland

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*Based on Statistical Report, U.S. Dept. Commerce, ed. 86, and Fisher, G. F., and Vavra, H. M.: Pub. Health Rep. 80:961 (Nov.) 1965.

Note: DEXTROSTIX is not meant to replace the more precise analytical laboratory procedures such as needed in glucose tolerance testing.

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mittee to Revise the Medical Practice Act and referred it to the Semiannual Session, 1967, for approval of the House of Delegates.

2. Ratified legal defense for several cases.

3. Heard of settlement, dismissal and awards in various legal cases against physicians.

4. Approved September 5, 6 and 7 as the dates for the 1968 Semiannual Meeting in Ocean City.

5. Renewed the Executive Secretary's contract for a three-year term on the same basis and with the same conditions as previously.

6. Approved expenditure of up to $7,500 from Library funds for reevaluation of the various rare books that are scattered throughout the stacks to provide a core for a History of Medicine department; removal of "out of scope" books from the stacks, to relieve about 20% of the stack space; and consideration of the recataloguing of the entire collection.

7. Authorized the sending of a letter of intent to the National Library of Medicine so as to ascertain more details about the possibility of constructing an addition to the north of the Faculty building for which 75% of the cost would be borne from federal funds. This does not commit the Faculty in any way.

8. Approved the Fee Schedule Committee's recommendation that the Faculty not renew its CHAMPUS contract (formerly Dependents' Medical Care program for members of the US Armed Forces); and urging that Blue Shield be used as a fiscal intermediary for payments either to physicians or to the dependents who receive care.

9. Deferred action on the report of the PL 89-97 Subcommittee, in connection with payments for services under Titles 18 and 19 of PL 89-97, until such time as legal opinions can be obtained on certain points therein.

10. Designated appointment of a committee to study the admission of Osteopaths to membership in Component Societies, the Faculty and the AMA, as well as to establish a policy for guidance of members in connection with hospital staff membership for Osteopaths.

11. Heard representatives of the Maryland Medical Political Action Committee and the American Medical Political Action Committee.

12. Deferred action until the June 1967 Council meeting on a proposed retirement program for Faculty members under the Med-Chi Insurance Trust.

13. Approved a Policy and Planning Committee recommendation that the State Board of Health and Mental Hygiene be designated as the agent for funds to discuss comprehensive health planning for Maryland.

14. Congratulated Donald J. Roop, MD, Council member, on his appointment as the new Baltimore County Health Officer.

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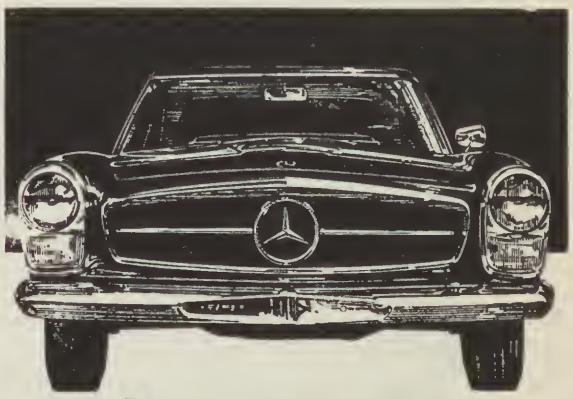
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EXECUTIVE SECRETARY'S NEWSLETTER

April, 1967

RESOLUTIONS FOR SEMIANNUAL SESSION

Resolutions for consideration at the Faculty's Semiannual Session scheduled for Friday, September 8, in Ocean City, Md., must be received in the Faculty office by

FRIDAY, JULY 14, 1967.

All Faculty members will be notified of resolutions received and the date of the Reference Committee meeting for discussion of them.

FIFTIETH AND FINAL REUNION

The 50th and final reunion of the Johns Hopkins Unit (Base Hospital #18) of WW I will be held on Saturday, June 17, 1967, at the Sheraton-Baltimore Inn, Baltimore.

Master of Ceremonies for this occasion is E. R. Desch, Clearwater Beach, Florida.

NEWS NOTES

Jacob H. Conn, M.D., gave the Academic Lecture at the Pennsylvania College of Podiatry when he spoke on the Interrelationship of Pain and Anxiety.

Abraham J. Mirkin, M.D., Cumberland, represents the AMA at the World Congress of Motoring Medicine in Vienna, Austria, May 7-13.

William Schuman, M.D., has had a lecture hall dedicated in his name at the North Charles General Hospital in recognition of his educational activities at the hospital.

Walter F. Ballinger, II, M.D., has been named Bixby Professor and Head of the Department of Surgery at the Washington University School of Medicine, St. Louis.

Bryan D. Brogdon, M.D., will assume the post of Professor of Radiology at the University of New Mexico School of Medicine in June.

George D. Zuidema, M.D., is a member of a 28-man committee on Surgical Education in

Medical Schools recently named by the American College of Surgeons.

Dr. Walter Ballinger has also been designated as chairman of the Pre and Post-operative Care postgraduate course at the ACS meeting in Chicago.

OPHTHALMOLOGISTS ACCEPT SPEAKING ENGAGEMENTS

Participating actively in the speakers' bureau operated by the Maryland Society for the Prevention of Blindness are the following Ophthalmologists: Drs. Alfred A. Filar, Vincent Eareckson, Arnall Patz, Abraham Kremen, Gregory Sophocleus and Richard E. Hoover.

FIRST AID ROOM IN ANNAPOLIS

The First Aid room sponsored by the Faculty, in cooperation with the Anne Arundel County Health Department, Medical Society and General Hospital was actively used again this year by both legislators and personnel working with them.

In the closing days of the session, most common item dispensed was antacid tablets and headache pills, for not uncommon complaints at that time.

DRUG CHANGE

Paregoric prescriptions have been changed from Class A to Class B by the Division of Drug Control, State Department of Health. This permits prescriptions for this drug to be telephoned to the pharmacist.

DEPENDENTS MEDICAL CARE PROGRAM CHANGE

All physicians are urged to read carefully the item contained in the latest issue of The Assemblyman, which explains in detail the recent billing changes made in the Armed Forces Dependents Medical Care program. (Formerly known as ODMC, it became the Comprehensive Health and Medical Program for Uniform Service, or CHAMPUS, a short time ago.)

John Sargeant

Executive Secretary

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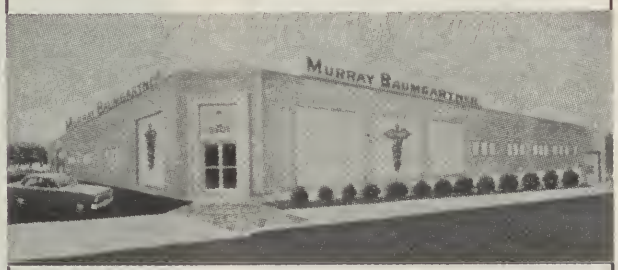
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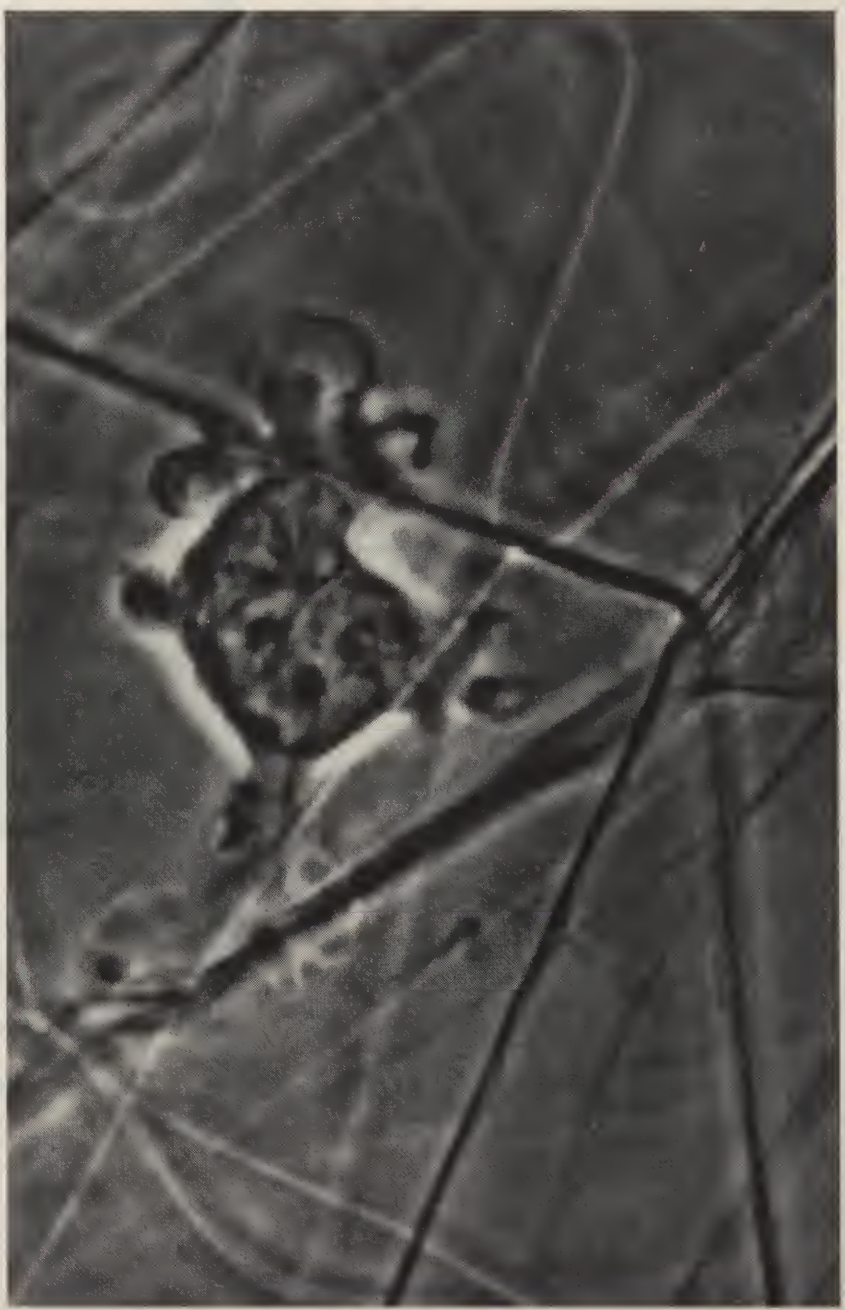
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INFLAMMATION: A cellular fight for life

A SYNTEX REPORT based on recently developed hypotheses about topical corticosteroids, including the cellular theories of inflammation by Thomas F. Dougherty, Ph.D., University of Utah.

You are looking at a fibroblast fighting for life. This cell—one of the most common found in connective tissue—has literally been poisoned by cytotoxins released from other cells that have ruptured. Soon, if the abnormal activity of this fibroblast does not cease, it, too, will rupture and die—one more casualty in the inflammatory wave of destruction precipitated by injury.

Until a short time ago no one had ever witnessed such a scene at the cellular level. Now, through advanced cinemicrographic techniques, it is possible to view and photograph the inflammatory process as produced experimentally in living animal tissue. This method permits new insight into the mechanism of inflammation and the role of corticosteroids in therapeutic management. Equally important, these techniques shed new light on factors that may make one corticosteroid more effective than another—factors that can be correlated with other chemical, biologic, and clinical parameters.

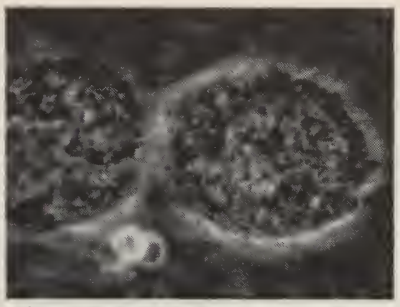


Visual evidence of how corticosteroids influence the inflammatory reaction

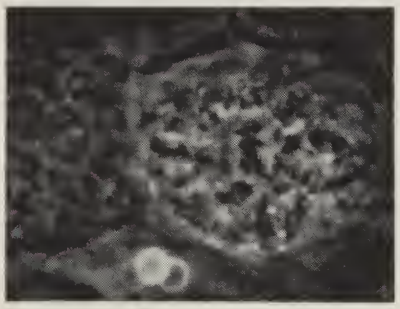
Working with phase-contrast cinemicrography on living animal tissue, Doctors Thomas F. Dougherty and David Berliner of the University of Utah College of Medicine have actually filmed cellular events that occur during the inflammatory reaction. This remarkable study* and additional work by these investigators, as well as by others, have established a new theoretical biologic basis for the antiinflammatory effect of the corticosteroids. (It must be noted that other theories, such as the lysosome or so-called "suicide bag" theory, have been postulated, although it is quite likely that there are more similarities than differences among the various theoretical models.)

The inflammatory wave of destruction

In this investigation an injurious injection of gelatin is used to set off an inflammatory reaction in living mouse tissue. What follows is a wave of destructive cellular activity that comprises the inflammatory response to injury. Mast cells (which contain heparin, serotonin and histamine) take up water, swell and rupture, releasing their contents, which are toxic outside the mast cell wall. These toxins, in turn, cause disintegration of other cells (such as fibroblasts) and the release of additional toxic material. Capillaries, too, take up water and leak unformed blood elements, causing edema. And polymorphonuclears, lymphocytes and perithelial cells invade the inflamed site. As a result of all these changes, the cellular environment reaches a state of turmoil.



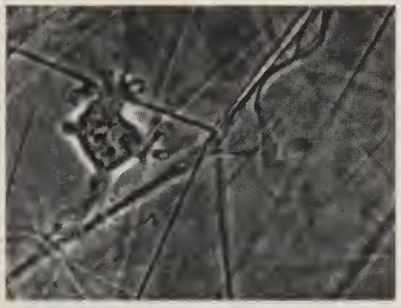
Phase-contrast microscopy showing mast cell before injury.



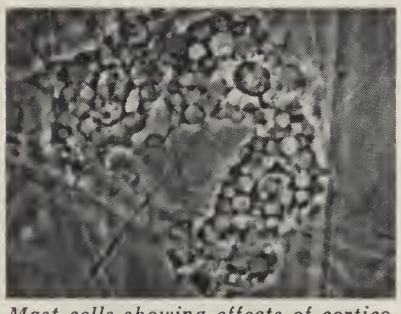
Mast cell (after injury) has broken up and released cytotoxins.

How corticosteroids change the picture

Corticosteroids appear to virtually stop the abnormal cellular activity that constitutes the inflammatory reaction. This permits the body's natural resources to clear up the inflamed area and repair the damaged tissue. This interpretation is supported by the fact that when the injurious gelatin solution is injected simultaneously with a corticosteroid — Synalar (fluocinolone acetonide) — the inflammatory pattern simply does not develop.



Fibroblast in high state of activity, much distorted.



Mast cells showing effects of corticosteroid action: cells are normal in size, shape and activity.



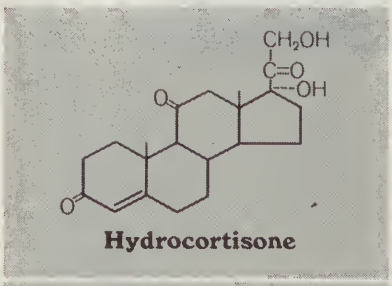
In summarizing his study Doctor Dougherty states: "...we also feel this work may explain why one corticosteroid helps a patient more rapidly and effectively than another. If it does, it is because one corticosteroid is the fastest, most effective inhibitor of the series of inflammatory events at the tissue level."

**A New View of Corticosteroid Action in Inflammatory Dermatoses,* a film based on this study, is now available from your Syntex representative.

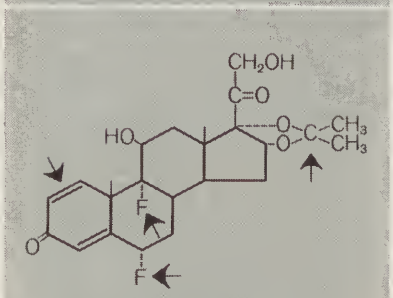
See last page for contraindications, precautions, side effects and dosage.

How advances in chemical design have achieved greater steroid potency

The chemical modification of corticosteroid molecules from the advent of hydrocortisone to the development of Synalar (fluocinolone acetonide) is a prime example of how biochemists can "design" to increase therapeutic activity and minimize undesirable side actions. Below, for example, we see the important changes that were made in reference to the hydrocortisone molecule to produce fluocinolone acetonide, one of the most active of all topical corticosteroids. As a result, a 0.01% preparation of Synalar (fluocinolone acetonide) has been reported to do the work of a 1% hydrocortisone product containing 100 times more cortiscosteroid. And it can often do it more effectively.



Hydrocortisone

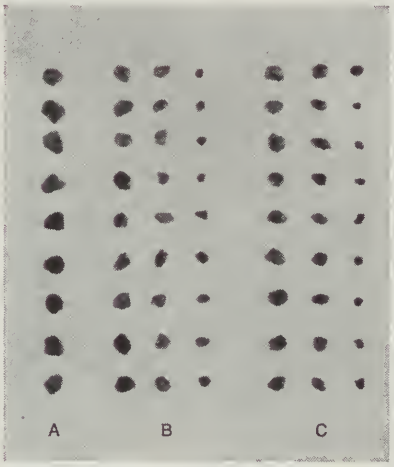


Fluocinolone Acetonide (Synalar)

- *a double bond between carbons 1 and 2*
- *fluorine substitutions at* both *the 6-α, and the 9-α positions*
- *the addition of the acetonide at the 16-α, 17-α positions, thus providing one of the most potent topical corticosteroids available.*

How bioassay tests are used to "predict" therapeutic potential

Biologic assays are another tool used by researchers to help establish the relative activity of corticosteroids. To date no single method of assaying corticosteroid activity has emerged as the ideal "yardstick" for predicting therapeutic potential. Taken together, however, these methods have proved useful. When such tests are run on various corticosteroids, a definite order of corticosteroid activity becomes evident. Compounds with the highest order of activity may be expected to merit clinical trial to establish their high therapeutic potential. When assayed by these methods, fluocinolone acetonide (Synalar) emerges as one of the most active topical corticosteroids, milligram for milligram, available for clinical application today.



THE THYMUS INVOLUTION ASSAY[1-4] is run on adrenalectomized rats. The sizes of the glands are measured, and the degree of involution caused by the steroid is determined as an indication of its potency. In the above photo, the comparative involution of thymus glands achieved with hydrocortisone and Synalar (fluocinolone acetonide) is shown. Untreated controls (A) show normal size. Group B – injected with 1, 2 and 4 mg. of hydrocortisone – show progressively smaller thymuses as does Group C – injected with fluocinolone acetonide – but with only 1/500th the dose of hydrocortisone.



THE ANTIGRANULOMA ASSAY[1-4] also utilizes adrenalectomized rats. Granulomas are induced by subcutaneous implantation of cotton pellets on either side of the thorax. The degree of granuloma inhibition achieved by a steroid reflects its potency. The above photo shows the inhibition of granuloma formation achieved with hydrocortisone and Synalar (fluocinolone acetonide). Untreated controls (A) show large, red granulomas adhering to the pellets. Group B, receiving hydrocortisone and Group C, receiving fluocinolone acetonide, show little, if any, granuloma formation. Fluocinolone acetonide produced the same effect as hydrocortisone with only 1/500th the dose. This assay, as well as the thymus involution assay, measures systemic rather than topical corticosteroid activity. Nevertheless, results by these methods correlate well with other assays and with the milligram potencies of topical steroids in current clinical use.

Worldwide clinical experience confirms the predictable therapeutic potential of Synalar

It is particularly gratifying that the promise of the advanced chemical design and high order of bioassay activity of Synalar (fluocinolone acetonide) has been confirmed by widespread therapeutic application. Indeed, the impressive clinical response rate of Synalar has been documented in no fewer than 232 papers from 22 countries.

Representative Clinical Results with Synalar*

Efficacy Documented in over 4,000 Patients

Condition	Number of Publications	Number of Patients	Significant Improvement†
Contact Dermatitis	27	750	713
Eczematous Dermatitis	21	472	409
Seborrheic Dermatitis	18	442	426
Atopic Dermatitis	24	460	426
Psoriasis	36	1,699	1,510
Neurodermatitis	18	351	324
Total	144	4,174	3,808

*Complete bibliography on request.

†Expressed by the authors as excellent, very good, good, complete remission of inflammation, etc.

PRESCRIBING INFORMATION

For initiation of therapy: Cream 0.025%, 5 and 15 Gm. tubes, 425 Gm. jars; *for emollient effect:* Ointment 0.025%, 15 Gm. tubes; *for maintenance therapy:* Cream 0.01%, 15 and 45 Gm. tubes, 120 Gm. jars; *for intertriginous or hairy sites:* Solution 0.01%, 20 cc. and 60 cc. plastic squeeze bottles; *for infected inflammatory dermatoses:* Neo-Synalar® Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes.

CONTRAINDICATIONS: Tuberculous, fungal, and most viral lesions of the skin, (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. PRECAUTIONS: Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. When severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. SIDE EFFECTS: Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. The neomycin in Neo-Synalar Cream rarely produces allergic reactions.

REFERENCES: 1. Lerner, L. J., Bianchi, A., Turkheimer, A. R., Singer, F. M., and Borman, A.: Anti-inflammatory steroids: potency, duration and modification of activities. Ann NY Acad Sci 116:1071 (Aug. 27) 1964. 2. Idem: Comparison of anti-granuloma, thymolytic and glucocorticoid activities of anti-inflammatory steroids. Proc Soc Exp Biol Med 116:385 (June) 1964. 3. Ringler, A.: Activities of adrenocorticosteroids in experimental animals and man, in Dorfman, R. I.: Methods of hormone research, New York, Academic Press, 1964. vol. III. pp. 234-280. 4. Gubersky, V. R.: To be published.

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From Washington

The US Department of Health, Education, and Welfare stated in a special report that both hospital charges and physicians' fees increased sharply last year. A continued increase in health care costs was predicted in the report, which was ordered last August by President Johnson.

Drugs were not a significant factor in the recent accelerated increase in health care prices, the report said, but it added that "drug prices are higher than they would be if there were more vigorous competition at either the manufacturing or drugstore level."

As for the two major components in the Medical Care Index, the report said physicians' fees, which had been rising about 3% a year from 1960 through 1965, went up 7.8% in 1966—the biggest annual increase since 1927; and hospital daily charges, which rose about 6% a year between 1960 and 1965, went up 16.5% in 1966—the largest annual increase in 18 years.

The increase in doctor fees was attributed to a combination of basic factors: more people are seeking doctors' services more often and the number of active physicians is increasing relatively slowly. The study found no evidence that Medicare, which went into effect last July 1, was a major factor in the rise in doctors' fees.

The increase in hospital charges was attributed largely to rising wages, which account for two-thirds of hospital costs, and increases in the price of things hospitals buy. The wage rise has not been offset by increased productivity, the report said, and rising standards of care in hospitals have required more expensive equipment and facilities.

Meantime, Robert J. Myers, the Social Security Administration's chief actuary, told the House Ways & Means Committee that hospital costs had risen much faster than the Administration anticipated since the Medicare plan went into effect. If they continue their upward spiral, the costs will eat away the safety margin included under the Medicare financing plan, Myers said.

The HEW report held out little hope for an early end to medical price increases; however, it recommended a series of actions "to slow down these increases and to promote the efficient use of medical care resources."

Recommendations in the report included:

—Comprehensive community health care systems should be developed, demonstrated, and evaluated.

—Group practice, especially prepaid group practice, should be encouraged.

—Private and public health insurance plans should be broadened to include more alternative types of medical care.

—States should move quickly to establish and support strong health planning agencies at the state and local levels.

—Cost-reducing methods of reorganizing the delivery of services in hospitals and other providers of health services should be developed, demonstrated, and implemented.

—Federally supported health care programs should be used to train physician assistants, evaluate their performance, and disseminate the results.

—Federal funds available under the Health Professions Educational Assistance Amendments of 1965 should be used to support and encourage innovations in health professionals' education and training that promote the efficient practice of medicine.

—HEW should undertake an intensive examination of frequently prescribed drugs to assess the therapeutic effectiveness of brand name products and their supposed generic equivalents.

—The Food and Drug Administration should provide doctors with authoritative information on the efficacy and side effects of all drugs.

—The HEW should call a national conference of leaders of the medical community and of public

A monthly summary of Washington news prepared in the Washington, DC, office of the American Medical Association.

representatives to discuss ways to improve the quality and efficiency of medical care delivery.

To carry out the recommendations in the report and allied directives from Johnson, HEW Secretary John W. Gardner said he would take a number of actions, including establishment of a National Center for Health Services Research and Development and calling of a national conference on medical care costs.

* * * * *

The American Medical Association contends there is not sufficient justification for a federal law that would ban dispensing of drugs and devices, such as eyeglasses, by physicians.

James Z. Appel, MD, immediate past president of the AMA, outlined the AMA position in testimony before the Senate Antitrust and Monopoly Subcommittee which held hearings on such legislation (S. 260) introduced by its chairman, Sen. Philip A. Hart (D., Mich.).

The legislation appeared to stand little chance of being approved by Congress, at least this year. Hart has unsuccessfully pushed similar legislation for the past few years.

The AMA believes that "federal legislation cannot be justified unless there is a compelling need," Appel testified. In this case, he said, "such a need does not exist."

"Organized medicine looks upon dispensing as neither immoral nor unethical in and of itself," the AMA official said. "Organized medicine believes—and the medical practice laws of the states confirm—that dispensing drugs and devices is a privilege granted to physicians in order that they may best serve the public interest.

". . . American medicine condemns any abuse of privilege. But the bill under consideration would withdraw the privilege entirely, regardless of its benefits for the many, because it is abused by the insignificant few."

From Coronado

Physicians and nurses must seek ways of establishing broader professional communication in order to satisfy the public's rising demand for more comprehensive, personalized medical care: this was an area of major agreement at the Third National Conference for Professional Nurses and Physicians held recently at Coronado, Calif.

The conference, jointly sponsored by the American Nurses' Association and the American Medical Association, brought together 47 selected representatives of each profession for two-and-one-half days of face-to-face talks about the needs of the sick person.

Samuel P. Martin, MD, provost, University of Florida Health Center, outlined the patient's needs in a keynote address at the start of the conference. Drawing upon a number of patient characteristics found in recent detailed studies, Dr. Martin concluded that patient needs are (1) to be considered as a person, not a disease syndrome; (2) a care system which is immediately available and obvious, and which has continuity over his life span and operates whether symptoms exist or not; (3) a system which relates closely to the culture, utilizes the forces of the social system, and directs its efforts not only toward the patient, but toward his total environment; and (4) assurance that the system of care is of the highest quality.

During workshop sessions there seemed to be general agreement that these needs can be met only through a multi-discipline, well coordinated health care system since the wide range of skills and knowledge required is beyond the comprehension of any one person, speciality or discipline. The application and coordination of these skills are generally the responsibility of the physician and nurse, many participants agreed.

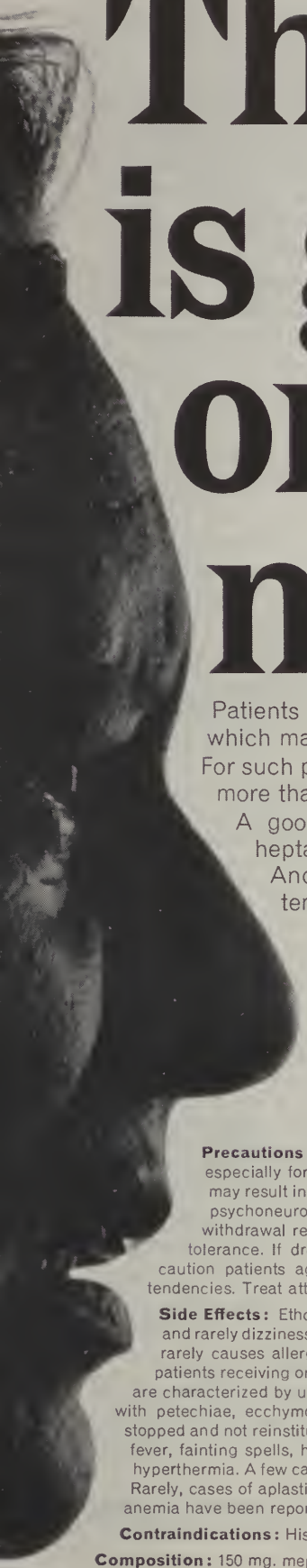
Another keynote speaker, Rhetaugh Graves Dumas, MSN, assistant professor, Yale University School of Nursing, said nurses and physicians view the patient from different perspectives.

"It is at the level of practice—the operational level, if you will—that views diverge both within and between medicine and nursing," she said. "Here each practitioner experiences the sick person within the limits imposed by professional prerogatives, functional responsibilities, interpersonal and technical competency, and physical and social framework within which he practices."

There was a consensus among the conference participants that this divergent viewpoint between the two disciplines must be overcome as a first and major step in fulfilling the needs of the patient. Improved communication between nurses and physicians at the local level was most often suggested as the ideal and most practical method of accomplishing this.

Workshop participants suggested the two pro-





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Contraindications: History of sensitivity or severe intolerance to aspirin or meprobamate.

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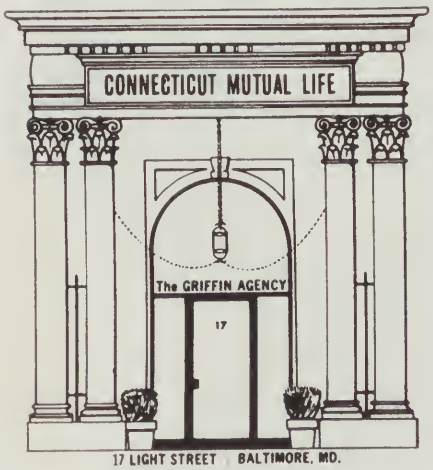
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fessions (1) promote establishment of joint liaison groups at the local level; (2) work together to develop model patient care plans designed to satisfy the patient's needs; (3) cooperate in altering established systems and methods which may tend to inhibit delivery of needed patient care; and (4) seek ways to provide time to bring the doctor and nurse together for formal and informal consultations and conferences concerning the care of the individual patient.

Among more controversial suggestions was that the two professions investigate the possibility of providing mutual educational experiences for physicians and nurses to establish an early rapport and appreciation for mutual problems.

From an AMA-ANA news release, March 1967.

From Chicago

The following opinion regarding the ethical responsibilities of physicians in prescribing drugs and devices was adopted by the Judicial Council of the AMA on March 12:

> It is unethical for a physician to be influenced in the prescribing of drugs or devices by his direct or indirect financial interest in a pharmaceutical firm or other supplier. It is immaterial whether the firm manufactures or repackages the products involved.
>
> It is unethical for a physician to own stock or have a direct or indirect financial interest in a firm that uses its relationship with physician-stockholders as a means of inducing or influencing them to prescribe the firm's products. Practicing physicians should divest themselves of any financial interest in firms that use this form of sales promotion. Reputable firms rely upon quality and efficacy to sell their products under competitive circumstances, and not upon appeal to physicians with financial involvements which might influence them in their prescribing.
>
> Prescribing for patients involves more than the designation of drugs or devices which are most likely to prove efficacious in the treatment of a patient. The physician has an ethical responsibility to assure that high quality products will be dispensed to his patient. Obviously, the benefits of the physician's skill are diminished if the patient receives drugs or devices of inferior quality.
>
> Inasmuch as the physician should also be mindful of the cost to his patients of drugs or devices he prescribes, he may properly discuss with patients both quality and cost.
>
> *From an AMA news release, March 1967.*

The Brain Drain

In the past eight years nearly 125,000 of Europe's best educated young people have in one way or another sought admittance to the United

States. They are graduate physicians in search of high-quality advanced education and the right to work unfettered by red tape and restrictions. Not finding it in their homelands, they turned to the United States.

Actually only a fraction of the 15,000 to 20,000 hopeful young doctors seeking entry each year ever arrive here. Figures of the Association of American Medical Colleges show that of those who take the Educational Council for Foreign Medical Graduates examination, only about one-fifth are accepted. Still, that means that about 4,000 are arriving from Europe annually to work and study in medical schools and hospitals. And a large number of these are staying to practice medicine.

They are of all nationalities—German, French, Austrian, Swedish, and especially English. And their loss has helped create what for Europe is a major problem—the so-called "brain drain."

Medicine is not the only branch of science involved in the brain drain. Europe is also losing engineers, chemists, physicists—in fact scientists and technicians in all areas—to the United States. But the major exodus seems to be among the medically oriented.

The implications of the flight of its scientifically educated young has European leaders frankly worried. There is concern that the continent has become undeveloped scientifically and technologically in comparison with the United States. Moreover, the gap is growing.

Even the Russians are fretful. For while they permit no emigration, they feel that because of the absence of scientific give-and-take in Europe generally, their own scientific programs are suffering.

Premier Kosygin of the Soviet Union made this clear during his visit to France. He proposed a "technological alliance" between Russian and Western Europe in order to end what he indicated was the dependence of Europe on advance made in the United States.

Far more concerned with the outcome of the brain drain, however, is Great Britain. The emigration of its young physicians has threatened Britain's National Health Service (NHS) with collapse.

According to their own surveys, about one-third of Britain's medical graduates are leaving the country each year. What's more, the number of medical students going into training has been



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An eminent barrister, R. H. Davison, outlining the British health service dilemma, reported in the British Medical Journal: "Not only has the NHS provided outrageous terms and conditions of service, it has completely failed to inspire respect among the younger members of the profession who see through its Fabian humbug."

He noted that even the supply of doctors being imported from Pakistan and India to help fill the vacuum of British doctors was dwindling, and criticized the government suggestion "that the advent of the Common Market will permit us to import Italian doctors to run our Health Service."

"Clearly," Davison wrote, "fourteen years of socialism have made us completely shameless, for no one can believe these policies to be in the national interest."

That was five years ago. Since then the tempo of emigration from Britain has accelerated despite government efforts.

Why? The consensus of those British physicians arriving in this country seems to be that they have no wish to be "hand maidens of the government." As one young resident said: "We're not exactly forced into servitude by the government, but we're not exactly free to practice our profession either. At least in America there is still a choice. But what would happen if that choice were removed, as it has been in Europe? Where would American doctors emigrate to?"

What has caused the drain of European brains? Is it money? Or is it something else?

Partly it is money. British interns say they work an average 100 hours a week for less than $200 a month. That figures out to about 45¢ an hour. But the greater issue clearly is one of "scientific climate." Over-regulated conditions have served to stymie scientific inquiry; without scientific inquiry there is lack of stimulation; and without stimulation scientific advancement suffers. So goes the analysis of what is wrong with science in Europe.

This, of course, is an oversimplification. But the fact is that the young, scientifically-oriented have shown by their desire to vacate Europe that something about the scientific climate there is inadequate, if not stifling. And whatever it is, the medical school graduates of Europe have turned to the United States in order to get into the

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mainstream of medical science.

American medicine became a lure to European doctors following World War II when it became clear that the United States had emerged in the forefront of medicine and, despite the efforts by some to downgrade the image of American medicine in order to foster a European system of medicine in this nation, the United States has continued to better its standing. If this were not so, the "brains" of Europe would not be seeking entry, for they crave scientific excellence along with freedom to practice their profession.

How good is medical science in America? A clear-cut answer is not easily obtained. Some critics, basing their argument wholly on one statistic or another, contend it is not very good. They maintain that because the infant mortality rates and the average life span in certain small European nations are somewhat better than our statistics, these nations have better medicine.

Actually such statistics fail dismally as a yardstick for measuring the quality of a nation's medicine. Totally ignored in the conjectures based on these tables are such factors as genetic makeup, economic conditions, educational levels and other matters including abortion laws, all of which are reflected in statistics. For example, one of the best assurances of a ripe old age is to be born into a family with a history of longevity. This is a matter of genes, and has nothing to do with medicine. Medicine of course, plays a role in longevity, but it is only one factor of several. Similarly, one of the best buffers against infant mortality is a mother well-educated in the facts of childbearing before she becomes pregnant.

The fact is, of course, medical and scientific quality cannot be based on one lone statistical table. Rather it must be judged on the sum total of numerous factors. Such a compilation clearly indicates that the young Europeans are probably right —the United States is the leader in medical science.

In the 21 years since World War II, 23 Americans have been awarded the Nobel Prize in medicine and physiology. That is more than was won by physicians and scientists from all of the other countries of the world combined.

In the same period, well over half of all the major new drug discoveries were developed in this country. As a matter of fact, 80% of the

prescriptions written today could not have been written ten years ago because the drugs did not exist then.

Medical progress cannot be measured only in the laboratory, however. It must also be measured in terms of people, disease, and facilities. Thus the fact that America was building 750 hospitals in the same time that England was building one also enters the picture.

So do such matters as the rate of death from various diseases. The death rate from cancer in America, for example, is well below the rate of Western Europe. And since cancer is treatable to some extent, our lower death rate could be interpreted as better medical treatment. The same holds true for other treatable diseases, including tuberculosis, pneumonia, strokes and influenza. All of these kill fewer people here, per capita, than in Western Europe.

What it all adds up to is that 4.5 million Americans alive today would be dead if medicine were practiced with the same amount of knowledge and the same tools as it was just 25 years ago. In that time span—in the past 25 years—medicine has learned more than it learned in the previous 50 centuries.

No one can assign a nationality to such knowledge—it is worldwide—but when it comes to teaching and applying that knowledge, the rest of the medical world looks to the United States for leadership.

AMA news release, Feb 1967.

"Bold New Approach"

An audience of 400, made up of senators, congressmen, government officials and community leaders from all parts of the country, attended the Washington premiere showing of the film *Bold New Approach* in the new Senate Office Building auditorium on March 21.

The film is a documentary portraying the way in which community mental health centers can be established and developed by local communities using Federal support to help finance construction and staffing of the centers, under terms of the Community Mental Health Centers Act.

Produced for the National Institute of Mental Health, Public Health Service, Department of Health, Education, and Welfare by the Mental Health Film Board, Inc., *Bold New Approach* draws its title from the late President Kennedy's 1963 health message to the 88th Congress. At that time, he called for "a bold, new approach" toward solving the problems of mental illness.

In welcoming guests at the premiere and reception, Senator Lister Hill (D. Ala.) said, "The size and composition of this audience is indicative of the widespread and growing interest of people across the entire country in our national mental health program, particularly in current efforts to establish community mental health centers in which comprehensive mental health services will one day be available to all who need them.

"We have made a solid beginning," the Senator continued, "but the demand for mental health services is so great that we cannot stop here. It was my privilege, acting in conjunction with Mr. Harley Staggers (D. W Va) in the House of Representatives, to introduce bills in this Congress to extend the community health program.

"With this new legislation, the centers program can continue to grow and more communities will be able to treat their mentally ill, their disturbed children and other individuals who have specific problems such as drug addiction or the misuse of alcohol. The proposed legislation is part of the current national effort to make all health services —including mental health services—available and accessible to everyone."

As of March 7, the Senator stated, Federal grants totalling $66,029,301 have been made to 157 community mental health centers in 44 States, Puerto Rico and the District of Columbia to serve an estimated 27 million Americans.

Bold New Approach depicts the center's revolutionary approach to the prevention and treatment of mental illness by dramatizing the plight of a young girl and the emotional problems of a middle-aged wage earner. Each receives appropriate treatment and rehabilitation through the range of services offered by their community mental health center.

The film also serves as a graphic guide to community groups interested in establishing a centers program by adding their existing mental health services.

Bold New Approach is available for sale and rental from the Mental Health Film Board, Inc., of New York, or on free loan through the Public Health Service Audiovisual Facility, Communicable Disease Center, Atlanta, Georgia.

NIMH news release, March 1967.

Federal Research Grants

"The American Medical Association should support in general the Federal biomedical research program . . . However . . . the AMA has an obligation to the public and to the medical profession to question any facet of the Federal biomedical research program which it may believe to be ill-advised."

This is the primary recommendation of the AMA's Commission on Research, named by the Board of Trustees two-and-one-half years ago to assess the impact of Federal government support upon research itself, and upon medical schools, the education of physicians and the provision of medical services.

The Commission, headed by former US Supreme Court Justice Charles E. Whittaker, of Kansas City, Mo, presented its report to the AMA Trustees following its seventh and final meeting on Feb. 3, 1967.

"While the findings of this Commission regarding Federal impact on medical research are on the whole favorable, the Commission has observed stresses and strains within the growth and development of Federally-sponsored research which call for remedial action," Justice Whittaker declared.

Wesley W. Hall, MD, of Reno, Nev, chairman of the AMA Board, said: "This report, because of the importance and current applicability of many of the issues considered, will undoubtedly evoke widespread interest. The Board, therefore, has approved its immediate publication. At a later date the Board will react formally to the report and, in addition, will submit it to the House of Delegates for final action." With submission of the report, the Commission completed its work and was discharged with thanks from the Board.

Other members of the Commission were Robert C. Hardin, MD, dean of the State University of Iowa College of Medicine, Iowa City; Irvin E. Hendryson, MD, Denver, an AMA trustee; Richard L. Meiling, MD, dean of the Ohio State University College of Medicine, Columbus, and an AMA delegate; Thomas W. Phelps, investment counselor with Scudder, Stevens & Clark, New York; Raymond M. Rice, MD, vice-president of Eli Lilly & Co., Indianapolis; William R. Willard, MD, vice-president of the University of Kentucky Medical Center, Lexington, and a member of the AMA Council on Medical Education; and David A. Wood, MD, director of the Cancer Research Institute of the University of California School of Medicine, San Francisco, and member of the AMA Council on Voluntary Health Agencies. Joseph D. Cooper, PhD, professor of government at Howard University, Washington, DC, was consultant to the Commission. Its secretary was Ernest B. Howard, MD, assistant executive vice-president of the AMA.

The full report of the Commission will be available shortly. Summaries of its conclusions and recommendations, as presented in an AMA *News Release*, are reprinted here, verbatim:

SUMMARY OF CONCLUSIONS OF THE COMMISSION

I

Responsive to the Board's first charge to the Commission to determine "the impact of Federal research grants on (a) medical education; (b) the institution involved; and (c) the nation's scientific and technical resources," the Commission concludes that:

1. The nation's great scientific and technical resources have been enormously expanded in the area of biomedical research since World War II and particularly in the last ten years as a result of leadership and emphasis provided by both the Executive and Legislative Branches of the Federal Government and resulting financial support. We concur in the general belief that the current level of adequacy and excellence of our biomedical research resources has never before been equaled, although it is probable that the abundant Federal funds for research have inescapably supported a measure of mediocrity as well as the nation's best in scientific medical talent.

2. Federal support of biomedical research has become a permanent element of our nation's policy. This support is responsive to popular demand that the conquest of disease and the betterment of the condition of man become national priorities.

3. The support of biomedical research has had a profound impact on medical schools, favorable in many respects, adverse in some, and complex in most. On the whole, medical school programs have been enriched through support of research activities. Furthermore, without the system of grants which has evolved in recent years, many medical schools would have been in danger of collapse, and biomedical research and educational programs would have been jeopardized. The most critical source of difficulty has been that support of the total responsibilities of medical schools has proceeded unevenly so that imbalances have developed among the interrelated areas of research, teaching, and patient care in some medical school faculties and in some teaching hospitals.

4. The heavy infusion of research dollars, particularly through selected faculty members and departments and independent research institutes and facilities, has glamorized research activity and contributed to a

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"flight from teaching" of individual investigators.

5. The Commission's most important conclusion with respect to its first charge is: The adverse effects of Federal research grants on medical schools arise from many sources. Primarily they arise from the imbalance caused by burgeoning financial support for research—in the midst of a relative scarcity of funds for educational programs.

6. As the principal source of biomedical research support, the National Institutes of Health has commendably avoided using its vast powers to influence academic decisions. Nevertheless, the principle still holds that a preponderance of Federal support tends in the long run to lead to Federal control. In the past few years, several developments have occurred which point to the possibility of increased Federal control over the purposes for which Federal research funds are to be used and over the manner in which they are expended.

7. The past rate of growth of support of biomedical research has not recently been maintained. Meanwhile the increasing cost of research has imposed a squeeze on available funds and thereby tightened competition for them. Within the past several years, the costs of supporting an investigator have doubled. Research proposals are becoming more sophisticated while equipment is becoming more complex and expensive. The net effect of these changes is to compel the establishment of priorities for funds and to increase the demand for accountability.

8. The study section arrangement organized by the NIH for review of proposed project grants through panels of outside academic experts (or peer groups) has been successful in identifying and supporting research of quality.

9. The policy of the Congress that universities and medical schools must share in the overhead cost of research projects has imposed difficulties upon many academic institutions. The policy of requiring the schools to share overhead costs, even though their shares may be relatively small, has been intended to insure that schools participate only in research that is deemed to be of such importance to the school's program that it is willing to commit some of its funds to the project. In view of the large volume of Federal research now conducted in the medical school, however, with the prospect that this may increase in the future, and in view of the hardly sufficient funds available to the schools to pay the costs of their basic operations, this "cost sharing" policy diverts institutional non-Federal dollars to research that are needed, and otherwise would be used, for teaching programs.

10. The current modest "institutional grants" to schools for independent allocation by the schools to their own faculty researchers have had a salutary effect in restoring at least some measure of institutional control. Several investigative bodies and many distinguished leaders are now urging—and we concur—that a higher percentage of the Federal research monies now going into project grants be shifted to institutional grants and that this money be administered by and in the discretion of the medical schools.

11. The emphasis in project grants has enriched the research capability of the more affluent schools, which are more abundantly endowed with distinguished investigators and both Federal and non-Federal funds, while leaving the other schools relatively poorer.

12. The technique of direct Government support of some investigators, albeit through the administrative machinery of the university, and the predominant use of project grants for supporting research have created problems in most medical schools. Particularly, they have tended to create divided loyalties and disruption of administrative authority.

13. It is widely recognized that the medical schools and their parent universities must share responsibility for whatever imbalances now exist, due to their failures to define their objectives and roles and to develop management capability commensurate with the complex relationships brought about by their Federally-financed expansions of activity.

II

The second charge to the Commission was to determine "The effect of the expanding Federal research role on the broad areas of medical service outside of medical education." The conclusions of the Commission are:

14. The improved quality of patient care currently available reflects, to a significant degree, the expanded research knowledge created in the last decade.

15. The prevailing patterns of disease have been changed profoundly by research progress. Advances in immunization and antimicrobial therapy, as well as public health innovations, have reduced many communicable diseases to controllable levels. Longevity has increased, neonatal mortality can be expected to continue its decline, and other health indices are showing

similar progress.

16. The research projects that will have the most important effects on medical service, certainly in the immediate future, are those relating to the development of new methods in the provision of health care and the administration of health services. These projects involve the study of the roles of different members of the health care team, the economics of health care, the role of the medical center in the health care complex, and the coordination and regionalization of health care services.

III

The third charge to the Commission was to determine "The effect of Federal spending on private giving and the ability of the latter to make a meaningful contribution." The Commission's conclusions relating to that charge are:

17. All sources of support of biochemical research, governmental, private foundation, and industrial, have increased in recent years. Non-governmental support would be considered significantly increased were it not for a much sharper relative increase of Federal funds for research. Consequently, the sheer preponderance of Federal support has made academic institutions primarily dependent on a single main source, with implications for loss of local autonomy.

18. Notwithstanding the sharp reduction in the ratio of private giving to Federal giving, private foundations still can make significant contributions by providing funds for talented investigators who, for one reason or another, do not receive Federal support and by making funds available for those unique and unusual projects which may not be endorsed by "peer groups."

19. With relatively few exceptions, major voluntary health agencies have tended to support research programs which parallel those funded with Federal dollars and to support many of the same investigators who receive Federal grants rather than assuming unique roles of independent initiative. Some who review the allocation of voluntary health agency grants also review the allocation of Federal support grants. Some voluntary health agencies have tended to overlook or ignore their roles as independent critics of Federal programs, as innovators, and as risk takers. Voluntary health agencies can make unique contributions in each of these areas.

IV

The fourth charge to the Commission was to determine "the scope of Federal medical research support and the mechanisms used." As this charge is informational, it is covered in the supporting body of this report.

V

The fifth charge to the Commission was to make such further conclusions . . . which the Commission shall deem advisable for inclusion in this report.

20. The best interests of science and medicine and of the public generally would be served by maintaining a pluralistic support of biomedical research. That is, there should be a diversity of sources of support with a diversity of judgments entering into the allocation of support. Thereby, institutions are more likely to retain their independent identity and their freedom of judgment.

21. Progress in the development of new agents for the diagnosis, prevention and treatment of disease is, we believe, hampered by current Federal patent policy. The problem arises because pharmaceutical companies, universities, and others are in danger of losing all of their investments and ensuing patent rights if and when use, however nominal, of Federal funds can be traced into the discovery or development of a new product. To protect their interests, sources of nongovernmental research have been tending to avoid the normal interplay of their scientists with Federally supported academic scientists.

SUMMARY OF RECOMMENDATIONS

In light of the foregoing and in response to the Board's fifth charge to make "such further conclusions and recommendations [as] the Commission shall deem advisable," the Commission makes the following recommendations to the Board of Trustees:

1. The American Medical Association should support in general the Federal biomedical research program. However, because in the public mind research tends to become enshrouded in such an aura of divinity as to exclude critical discussion and analysis of all that is advanced in its name, the AMA has an obligation to the public and to the medical profession to question any facet of the Federal biomedical research program which it may believe to be ill-advised or which it be-





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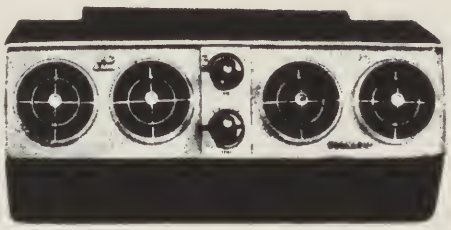
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lieves to be in need of constructive counsel.

2. The programs of the National Institutes of Health should be recognized for their contributions to the national biomedical research effort.

3. The Council on Medical Education of the AMA, in cooperation with other interested organizations, should be asked to make additional and progressive studies on the effects of research grants on teaching in medical schools. It should seek and recommend means for providing enhanced status and rewards for excellence in teaching.

4. The AMA should support responsible action designed to make available, to selected schools of good potential which have not developed adequate research establishments, special "development" funds to initiate or enlarge their research programs. These grants should also foster better geographical distribution of "centers of research excellence" among medical schools and universities.

5. The AMA should urge that the purpose of grants be identified precisely so that the Congress and the nation may know, with reasonable certainty, what is being supported, as a basis for future decision making.

6. To strengthen the review mechanism, membership on NIH study sections should provide for a sufficient rotation to ensure continuous infusion of new blood and to prevent the development of a monolithic, elite, decision-making "establishment." The same principles of rotation should apply to the Advisory Councils of the NIH. While due attention should be given to such factors as geographic distribution, the main consideration in appointing members to the Advisory Councils should be professional attainment and eminence of judgment.

7. A new statutory mechanism of overall review and counsel, in an advisory relationship to the director of the National Institutes of Health, should be established in order to assist in overall program planning and to provide additional checks and balances on program decisions. Membership on this advisory group should consist of men and women of demonstrated professional eminence and judgment.* We believe the advisory body should have independent status, under law, to assure that its recommedations and actions will have their intended impact regardless of changes in administrative leadership.

8. Accountability for disbursement of public funds should be maintained, but this accountability should depend primarily on strengthening of the administrative capabilities of educational institutions.

9. The AMA should urge and support legislation providing for Federal reimbursement of all allocable institutional costs of research projects authorized and funded by the Federal Government.

10. The AMA should urge and support legislation and administrative action designed to shift more decision-making responsibility for biomedical research from NIH to participating research institutions. To this end, increased use of the "institutional grant" and of the "program grant" should be actively supported. Developments relating to, or affecting, the mix of institutional, program and project grants to academic institutions should be carefully and continuously studied and analyzed for future guidance.

11. The AMA, in cooperation with other interested organizations, should conduct workshops and seminars of academic and medical school leaders and of those Federal administrators who grant and administer Federal research funds, to review mutual responsibilities and relationships, to conduct discussions of developing problems, and to develop new techniques for the better use and management of the vast Federal funds now being made available.

12. Because of the rapid changes which are occurring in the organization of medical practice and the financing of health care, research in the delivery of health care is of great importance and should be encouraged, provided it is conducted under proper auspices in accordance with sound research design and methodology.

13. The imbalance between biomedical research and education caused by the heavy, but desirable, Federal support of research, should be corrected by supporting measures that will materially increase both private and public funds for the support of the educational programs of the medical schools. First, among these measures, a more liberal income tax treatment should be allowed to the donors of private funds for medical education, to create increased incentives for them to contribute to medical education. Second, there should be allotted a greatly increased amount for operational expenses of medical schools, to be matched by those schools through private or local governmental sources. Every effort should be made to keep the Federal contribution on a supplemental basis, and the AMA should not support legislation that fails to do so.

14. The basic principles presented by the pharmaceutical industry on June 1, 1965, before the Subcommittee on Patents of the Senate Judiciary Committee, should be endorsed, namely:

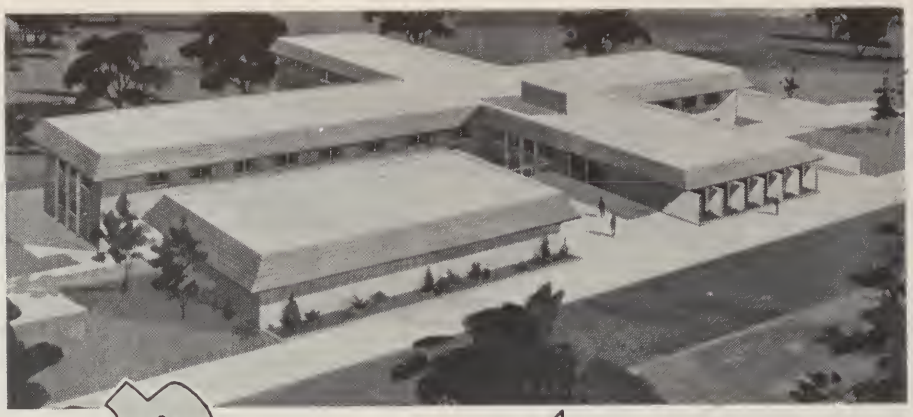
a. Provision should be made, in substantially every case, for the grant or license of exclusive rights in a scientific medical discovery to some industrial concern to assure that drug inventions, even if resulting in some part from Government-financed research, are really developed and made commercially available to the people.

b. When Government funds have solely or primarily developed the invention, it is equitable and rational for the Government to hold the proprietary rights to the invention and to receive reasonable royalties from a licensee, or from licensees, who will manufacture and commercially market the invention.

c. Where Government funds did not solely or primarily produce discovery and development of the invention, the cooperating contractor-developer alone should have the proprietary rights in the invention.

15. The Board of Trustees should provide for a continuing watch and review of developments in the areas studied by its Commission on Research.

*The Commission notes that the director of the NIH has, subsequent to the first drafting of this recommendation, created such an advisory body by administrative action. The Commission commends the director for this move.



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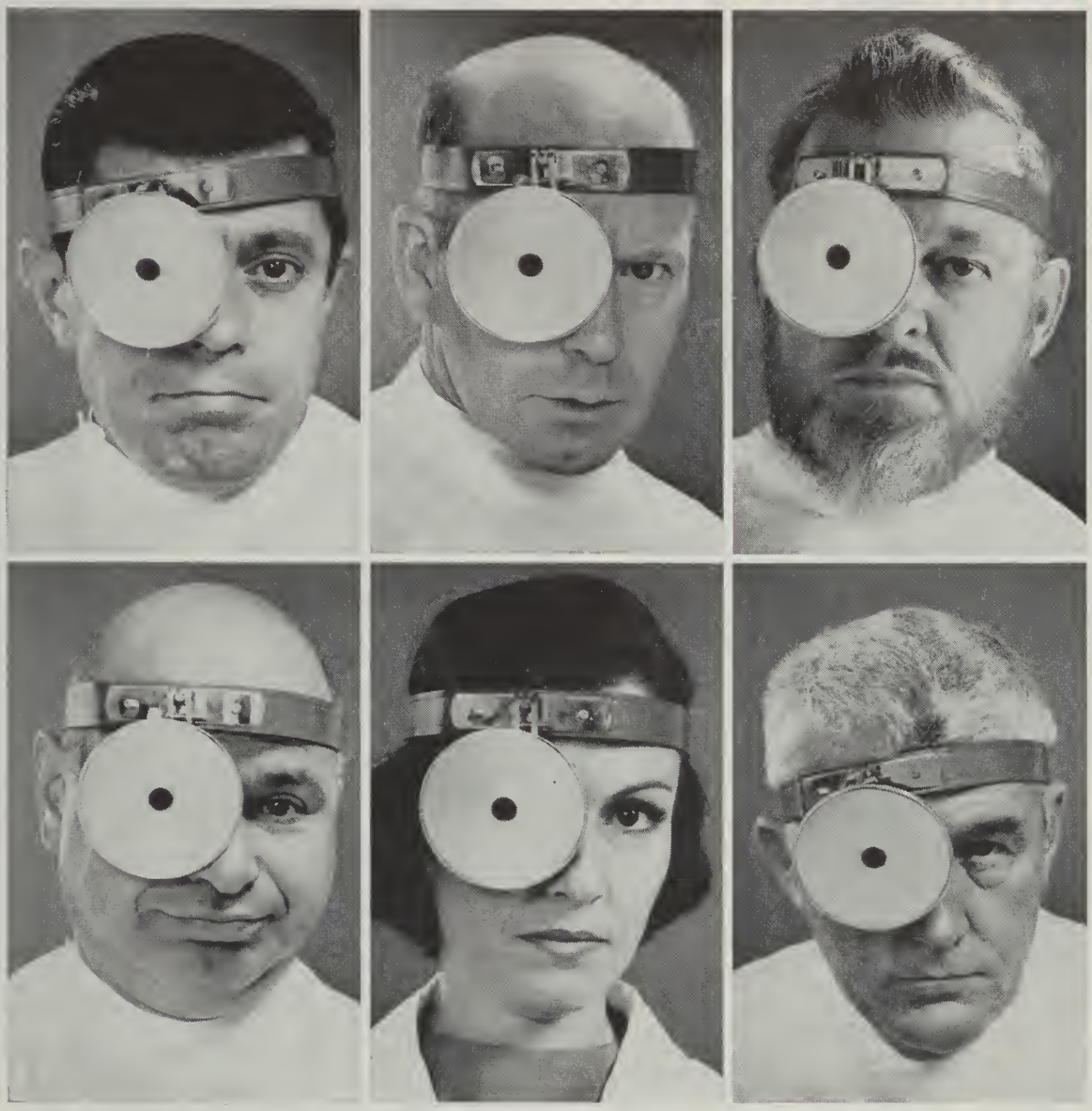
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"All Otolaryngologists are Alike"

Just look at them and you can see how much they have in common. Besides, they all go through pretty much the same training, and pass the same kinds of tests, and measure up to the same sort of standards. Therefore, all otolaryngologists are alike. Right?

Wrong! But that's no more preposterous than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more exacting. In fact, there are at least nine *specific differences* involving moisture content, purity, potency and speed of tablet disintegration, which make the manufacture of Bayer® Aspirin so different.

These Bayer standards result in significant product benefits, including gentleness to the stomach and product stability, that enable Bayer Aspirin tablets to *stay* strong and gentle until they are taken.

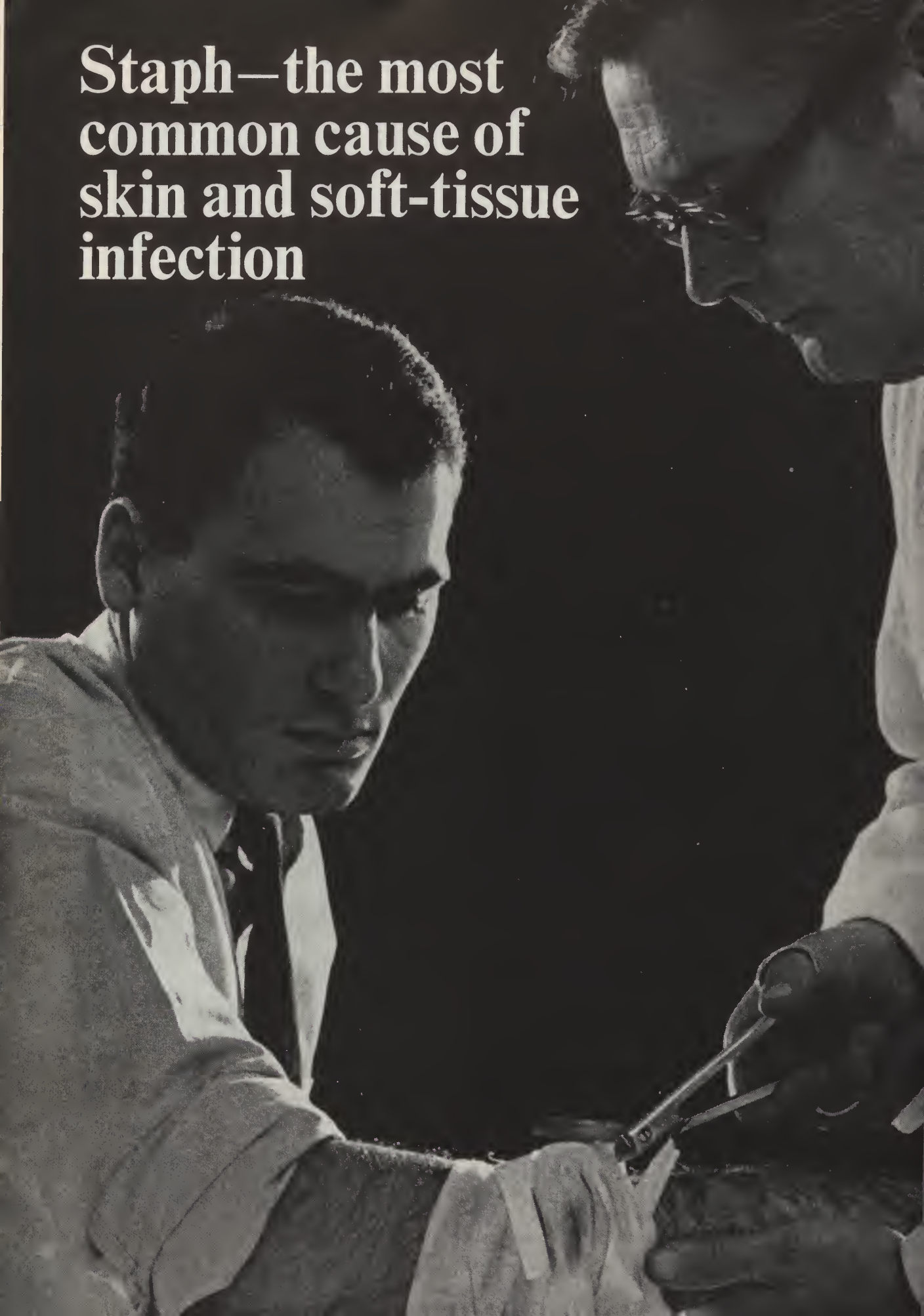
So next time you hear someone say that *all* aspirin tablets are alike, you can say, with confidence, that "it just isn't so."

You might also say that all otolaryngologists aren't alike, either.





Staph—the most common cause of skin and soft-tissue infection



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Staph—the most common cause of skin and soft-tissue infection—also is responsible for many more serious infections, such as pneumonia, osteomyelitis, and septicemia. Often, a seemingly minor skin infection is the source of metastatic spread to deeper structures. When findings on culture incriminate staph as the cause, Prostaphlin (sodium oxacillin) will provide specific effective therapy.

Bactericidal effectiveness. Hardly a staph organism can resist the bactericidal action of Prostaphlin (sodium oxacillin), as shown by a 34-month *in vitro* study. Of all staph isolates tested, 99.5% were sensitive to oxacillin.[1]

Clinically proven. There is a high correlation between these *in vitro* findings and clinical results. Of 610 patients treated with Prostaphlin (sodium oxacillin), 89.8% were reported cured or improved, including those with staph infections resistant to penicillin G.[2] And since resistance does not appear to develop *in vivo,* therapy with oxacillin can be extended when necessary.

Outstanding safety record. Besides being staph-specific and rapidly absorbed—Prostaphlin (sodium oxacillin) has established an outstanding record of safety during five years of widespread clinical use. Continuous high blood levels of oxacillin have not produced toxic effects on kidney function, assuring a significant margin of safety. However, as with all penicillins, the possibility of allergic response should be considered.

Capsules, Oral Solution and Injectable. Prostaphlin (sodium oxacillin) is available in three flexible dosage forms to suit the age of the patient and severity of infection—capsules, an oral solution for pediatric use, and multi-dose vials for injection, I.M. or I.V.

PRESCRIBING INFORMATION: For complete information, consult Official Package Circular. *Indications:* Infections caused by Staphylococci, particularly those due to penicillin G-resistant Staphylococci. *Contraindications:* A history of severe allergic reactions to penicillin. *Precautions:* Typical penicillin-allergic reactions may occur. Safety for use in pregnancy and premature infants is not established. Because of limited experience, use cautiously and evaluate organ system function frequently in neonates. Mycotic or bacterial superinfections may occur. Assess renal, hematopoietic and hepatic function intermittently during long-term therapy. *Adverse Reactions:* Skin rashes, pruritus, urticaria, eosinophilia, nausea, vomiting, diarrhea, fever and occasional anaphylaxis. Rare cases of reversible hepatocellular dysfunction have occurred. Moderate SGOT elevations have been noted. Thrombophlebitis has occurred occasionally during intravenous therapy and leukopenia was noted in two cases. *Usual Oral Dosage:* Adults: 500 mg. *q.*4 or *q.*6*h.* Children: 50 mg./Kg./day. *Usual Parenteral Dosage:* Adults: 250-500 mg. *q.*4 or *q.*6*h.* Children: 50 mg./Kg./day. Treat beta-hemolytic streptococcal infections for at least 10 days. Give oral drug 1 to 2 hours before meals. *Supplied:* Capsules—250 and 500 mg. in bottles of 48. Injectable—250 mg., 500 mg., and 1 Gm. dry filled vial for I.M./I.V. use. For Oral Solution—100 ml. bottle, 250 mg./5 ml. when reconstituted. **A.H.F.S. CATEGORY: 8:12.6**

References: 1. Abstracted from *Antibiotic Sensitivity of Staphylococci Studied from November 1962 through August 1965,* reported by Griffith, L.J., Staphylococcus Reference Laboratory, V.A. Hospital, Batavia, N.Y. 2. Data on file, Bristol Laboratories.

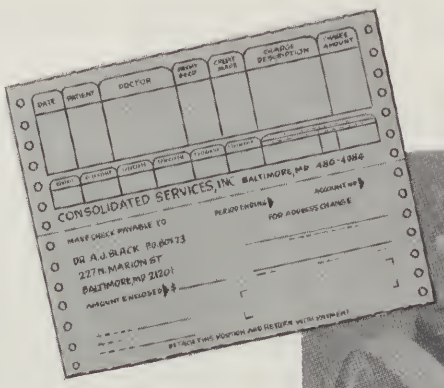
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Physicians' Placement Service

When the rapidly approaching end of World War II loomed on the horizon in 1944, physicians on the home front foresaw the imperative need to establish an organized program to help their military counterparts return to civilian practice.

So, in December of that year, the House of Delegates of the American Medical Association established a Bureau of Information to "assist returning medical officers in their educational, licensure and placement problems."

Since the Bureau had been envisioned only as a temporary project, it was abolished in November, 1947, because it was logically assumed that its purpose—relocation of medical officers—had by then been largely accomplished. Its work was transferred to the Council on Medical Service until the "tapering off" process of service requests was completed.

But the requests never stopped. The war, directly or indirectly, had spurred profound changes. The wartime interruption of their medical practices gave medical officers an opportunity to think out their futures. It opened their eyes to new challenges and opportunities. Many physicians chose to capitalize on the chance to continue their medical education and enter specialty training.

Population patterns were changing. Some physicians took this as their cue to search for more attractive locations in which to practice. Others decided they wanted to seek out opportunities in entirely different geographic locations which held personal appeal for them. The unprecedented, uninterrupted period of post-war prosperity has served to multiply this mobility.

Consequently, the service originally performed as a temporary expedient by the Bureau of Information not only never stopped, but has mushroomed into a major, continuing AMA service to physicians, those seeking physicians and to the nation at large.

Established as the successor unit to the Bureau in 1948, the AMA Physicians' Placement Service has processed applications from 26,140 physicians seeking to be "placed," and registered 31,760 openings during its 18 years of existence. The service is provided without any charge or obligation.

Indicative of the increasingly significant role being played by PPS on a national level is the fact that it had 3,196 openings registered and 2,750 physician registrants in 1966. Back in 1948 it had a mere 200 openings and three times that number of registrants.

The AMA Physicians' Placement Service works closely with all state medical societies, about two-thirds of which have ongoing placement programs, and also with county medical societies that have such programs. It exchanges information with them on registrant applications and practice opportunities of mutual interest.

But its dominant role and its chief reason for existence lie in bringing together physicians and opportunities that are in different states or geographic areas.

Strictly speaking, the AMA Physicians' Placement Service is not a "placement" service at all. Its job is to supply information to applicants and those listing openings in an attempt to match their respective needs—to help find the "right" physician for the "right" location or position. Once brought together, two interested parties then seek to work out mutually satisfactory arrangements.

As a matter of fact, PPS cannot gauge with any reasonable degree of accuracy how many physicians it has helped to "place." While it is interested in knowing the answer, the information often is not made available since a good many registrants do not report their final status. The number of "placements" is, however, believed to be substantial.

A "bonus" effect of the service is that regis-

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trants pass along the word about openings to other physicians who they think may be interested in a particular opportunity. Placements frequently result from these word-of-mouth contacts. Even more frequently, registrants are led to other opportunities they find more attractive as the result of PPS-originated contacts.

In January, for example, a former general practitioner who had gone on to complete his residency in anesthesiology reported that he had decided to accept a position in either Indianapolis or a city in northern Michigan. Although neither position was listed with PPS, he pointed out that he had learned of both opportunities through contacts it had produced.

Many openings are filled rapidly. Some, however, take considerable time.

A physician from Minot, ND, for example, searched for nearly a year and a half, traveling considerably in the process, before he found the man having the very special qualifications required to work with him in a "loose association" arrangement. Needed was a cardiologist with extensive sub-specialty training in cardio-pulmonary diseases. Outstanding new facilities were available for conducting work in this area. Precisely filling the bill was a cardiologist who had just completed his military obligation. His background included five years of the sub-specialty training required.

"I never dreamed I'd wind up in North Dakota," the new associate said. "It was the furthest place from my mind, but the opportunity—the new facilities, the nature of the practice and the arrangements—met my needs perfectly."

Although PPS is but one of several sources utilized in finding physicians, some employers have experienced their best "outside" results with it.

Said the procurement director of a well-established Wisconsin clinic with several branch offices:

> "In 1966, 14 physicians signed contracts with us. Four of these were referred by the AMA Physicians' Placement Service. Your placement service was the only one of real value. We reached all the other new associates either through classified ads or personal contacts."

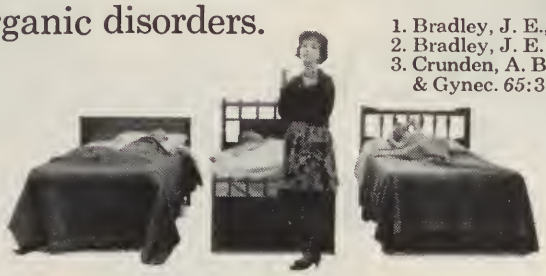
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1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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practice—solo, partnership, group, clinic or association—but it is becoming increasingly involved in other areas, exclusive of the teaching and research fields, in which openings are few and are best handled by direct personal contact or by word of mouth. In 1966, there were 215 openings listed in industrial, institutional, public health or school or college health positions.

Occasional requests are received concerning practice opportunities outside the US, but such openings exist almost exclusively in underdeveloped countries in Africa, Asia and Latin America. Currently, about 90 such openings, including five in Viet Nam, are listed by governmental agencies, private and denominational missionary groups, and industries.

While PPS lends assistance to physicians of all ages and interests, much of its activity centers upon those seeking their first place to practice. Last year more than 300 applicants made personal visits to the AMA headquarters to discuss opportunities to practice or physician manpower needs.

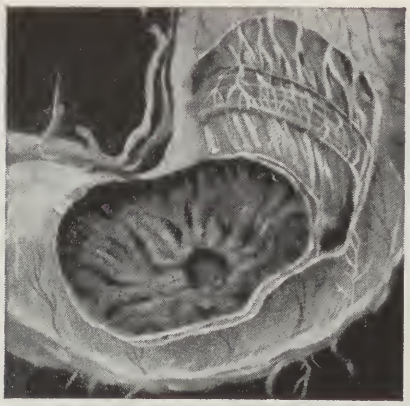
"Approximately 70% of physicians registering with us are looking for their first position," pointed out Mrs. Ann Johnson, director of the service. "They are either just completing internship or residency training, or completing military service."

Under a brand new program to be initiatied by mid-year, the Physicians' Placement Service will concentrate upon finding places to practice—full- or part-time—for physicians who have not recently been engaged in active practice. These will include older physicians who have been retired, women physicians who temporarily have abandoned medical practice, and physicians who have been engaged in other areas of work.

The mechanics of the Physicians' Placement Service are relatively simple. Each applicant is asked to fill out a brief questionnaire, on which he is to list his background, education, training, personal history and references, the type of position sought and the state or geographical area preferred.

A similar form is completed by those listing opportunities to practice. This contains such pertinent information as the type of community, type of specialty training required, type of practice, any age and special requirements, financial arrangements, whether there is an opportunity for

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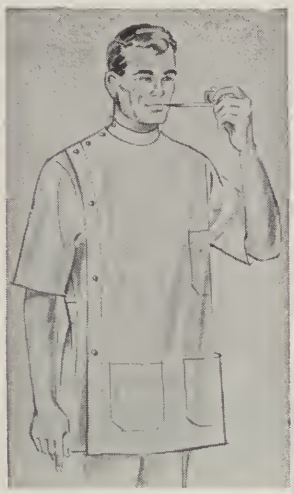
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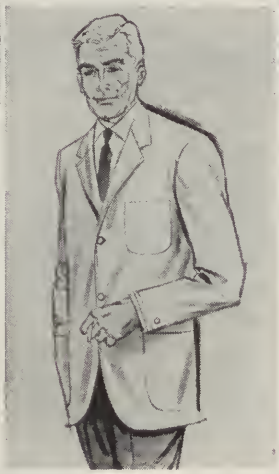
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partnership, available hospital facilities, type of schools available and what type of office space is available.

Each applicant is asked whether he wants a position in his home state only, in different states in the immediate home region, in the home *or* a new region, in a new region only, or has no preference. Geographic regions are divided into six categories—New England and Middle Atlantic, South, Midwest, Southwest, Mountain States, and Pacific States.

Let's assume, for instance, that you are an internist in solo practice in Chicago, but would like to enter group practice in one of the Mountain States because you and your family enjoy the climate, are avid outdoor enthusiasts and feel that you would prefer a relaxed way of life that you are likely to find in this geographic area. You desire a location in a city of 25,000- 100,000 population and specify that it must have a church of your faith. You also specify what compensation you expect to receive.

In filling out your application, you find that PPS will circulate your resume on a blind basis since you prefer to remain unidentified.

Unless you have specified otherwise, a copy of your coded application will automatically be sent to each of the state medical association placement services in this geographic region.

Shortly thereafter, you will receive from PPS a list of all current openings for internists. You also will be advised that PPS will forward a copy of your coded resume to all individuals, groups and communities having openings meeting your spec-

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ifications.

PPS then will forward you any letters from interested parties. If a position interests you, it is up to you to follow up by initiating contact. PPS has then fulfilled its role as intermediary by supplying both interested parties with information. It will, however, continue to send you descriptions of new openings until you advise that you have either accepted a position or are no longer interested in relocating.

In addition to the placement service, PPS also helps the practicing physician by providing carefully researched information to serve as a guide in planning physicians' medical facilities and managing medical practice. It also provides communities with information about the Community Medical Assistance Program for rural communities, a plan carried out cooperatively by the AMA and Sears-Roebuck Foundation.

If you ever consider relocating or entering a different type of practice, are looking for a prospective partner, associate or an additional physician for your community, or are thinking about building new office facilities or modernizing present ones, you will certainly find it advantageous to find what the AMA Physicians' Placement Service has to offer. And if you hear of someone who is "looking," you may do him a big favor by referring him to PPS.

Publications List

The following publications, describing various services provided by the PPS, may be obtained free of charge by writing to Physicians' Placement Service, American Medical Association, 535 North Dearborn Street, Chicago, Ill. 60610.

Finding a Place to Practice—an eight-page pamphlet describing the Physicians' Placement Service and outlining sources and factors to be considered in choosing a place to practice or relocate.

The Business Side of Medical Practice—a 56-page brochure containing detailed information covering the business aspects of conducting medical practice.

A Planning Guide for Physicians' Medical Facilities—a 54-page brochure containing valuable guides for established physicians seeking to build or modernize medical facilities.

The Sears-Roebuck Foundation Medical Cen-

ter—a four-page pamphlet describing (1) architectural plans for a rural medical building and (2) the Community Medical Assistance Program.

What Do You Know About Physicians' Placement Service?—a four-page pamphlet.

A Doctor For Your Community—a 19-page pamphlet providing guidelines for communities to follow when undertaking to procure a physician.

Immunization Campaign

Probably more than two million American youngsters suffered measles during 1966. This still-common childhood disease that should now be uncommon causes about 500 deaths a year, leaves many of its victims with deafness or mental defects and triggers secondary diseases such as pneumonia and encephalitis.

Yet all of these cases could have been prevented through the use of safe, effective measles vaccines, one of which has been available since the spring of 1963.

The same is true of the 300 cases of tetanus, 164 cases of diphtheria and the 72 cases of polio which were reported in 1965 by the US Public Health Service. These three diseases, a year earlier, caused 238 deaths.

That's why the American Medical Association has called upon the nation's medical societies and individual physicians to lead the battle to eradicate these easily preventable diseases by conducting intensive local immunization campaigns in cooperation with public health departments, specialty societies, health agencies and health educators.

To encourage such local efforts, the AMA, through its Task Force on Health Education to Promote Immunization, has developed a comprehensive kit of basic communications materials and guidelines designed to serve as the backbone for whatever type of immunization program is deemed desirable locally.

One of these kits, each containing approximately 25 basic communications tools ranging from a letter to mothers (in pamphlet form) to materials created for use in the mass media, was sent in March to executive secretaries and secretaries of the nearly 2,000 state and local medical societies.

(continued)

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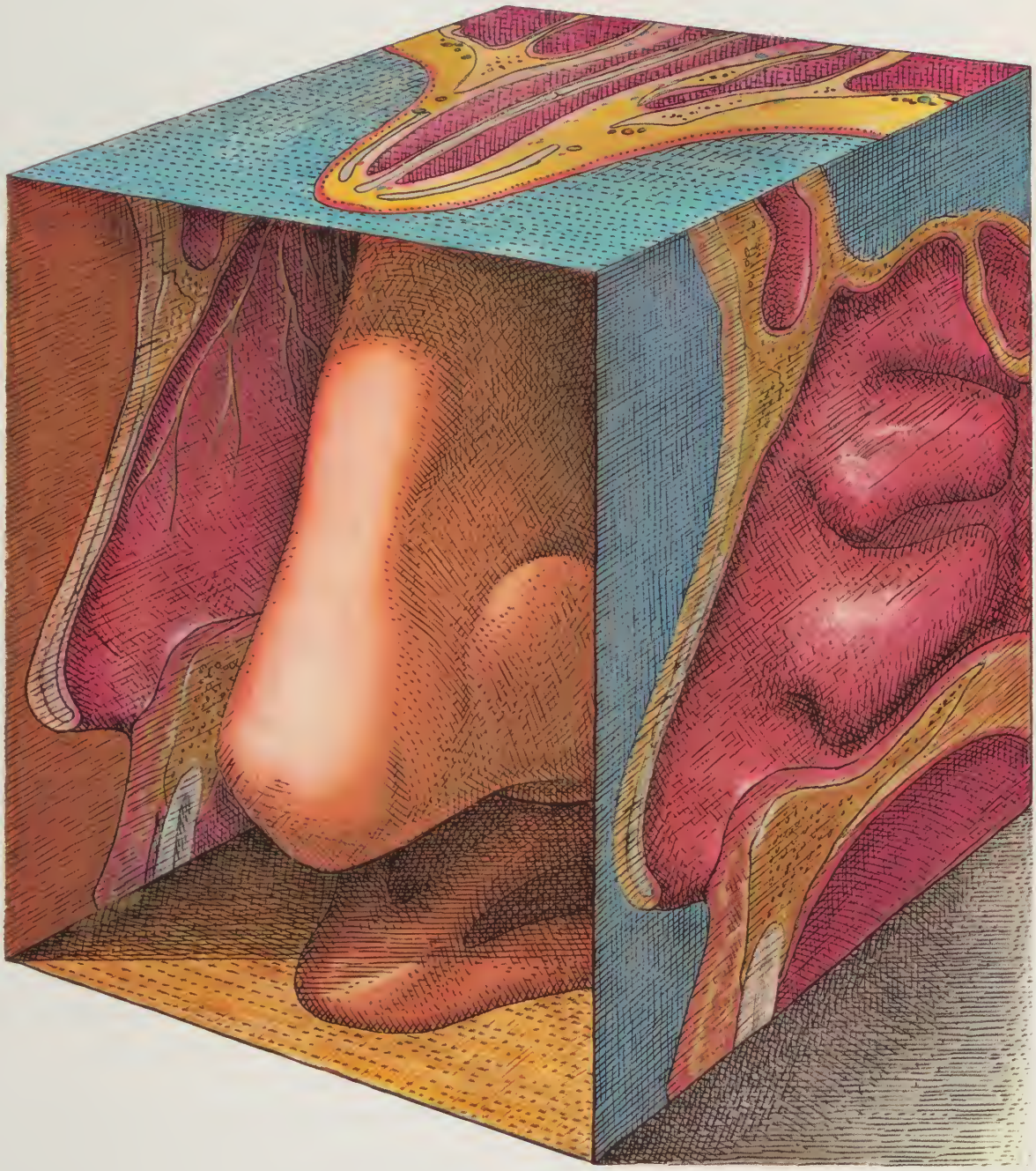
Materials contained in the kit are keyed toward encouraging individuals to obtain immunization from their personal physician, but can also be adapted by local medical societies wishing to conduct promotions of other types. Physicians officially designated to organize local programs can obtain a kit by writing the Health Education Department, American Medical Association, 535 North Dearborn Street, Chicago, Ill. 60610.

Campaign materials in the kit were developed by members of 14 AMA departments and four AMA divisions at the direction of the Council on Environmental and Public Health and as a direct outgrowth of the AMA Symposium on Immunization held at Atlanta last October in cooperation

spring 1967

DORSEY Season

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this issue: the ubiquitous world of summer allergies



the ubiquitous world of summer allergies

Donald L. Unger, M.D. • Clinical Assistant Professor, Department of Medicine (Allergy), Stritch School of Medicine (Loyola).

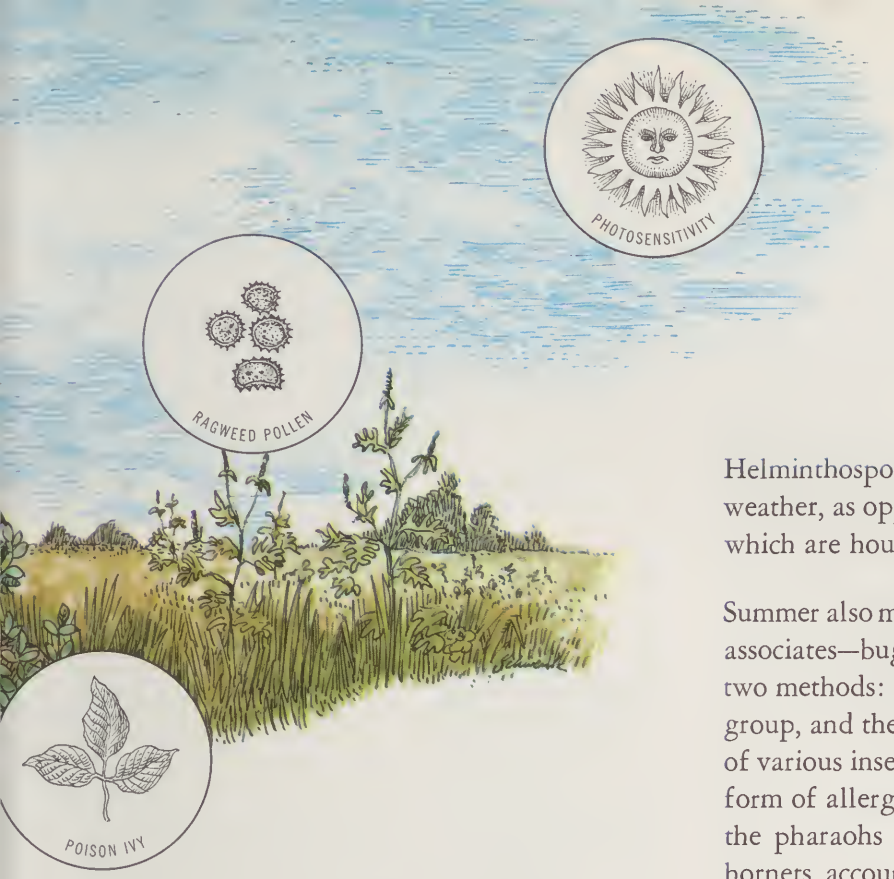
In the Spring a young man's fancy lightly turns to thoughts of—allergies. This is at least true of the 10% of the population who have hay fever and the 4% who have asthma.[1] The snow melts, the trees blossom and the noses run. Patients who were fine all winter may not be enthralled by the sight of the first robin or the blossoming of a crocus, for their appearances may precede the "sneezin' season."

Allergies in general can be divided into winter allergies and summer allergies. In the winter the main problems are inside the house: e.g. dogs, cats, dust and feathers. Houses in the northern half of the country become so dry that it becomes essential to add humidity to the home; this is a far cry from the damp summer months with the moldy basements and need for dehumidifiers.

Early in April trees begin to pollinate, with each tree having about a two week period of pollination. A particular patient may be sensitive to only one tree and thus have his hay fever for such a short time that he thinks he has a cold.[2] The entire tree season starts about April 1 and ends about Memorial Day, although all hay fever seasons are blurred and prolonged in the southern part of the country. Tree pollen is usually very heavy and a person may well have most of his exposure from those trees immediately surrounding his home.

Grasses pollinate from about May 15 until July 4, and cause "rose fever." Grass pollens are somewhat lighter and more buoyant than tree pollens, and are much more ubiquitous. While there are several varieties of grasses in the United States, they are so closely related antigenically that a person sensitive to one is generally sensitive to them all.[3] Thus, while the tree season is really several small seasons intertwined, the grass season will usually result in symptoms for a more prolonged period. Obviously, a grass-sensitive patient will have trouble only when grass is pollinating—he will have to think of another excuse not to mow the lawn after July 4.

Ragweed is the "Big Daddy" of them all in the eastern two-thirds of the country. Pollination is generally from mid-August until the end of September, with the predicted lower counts and longer seasons



in the southern part of the country. Ragweed is a very light pollen which may be windborne for hundreds of miles. An interesting study was made in New York City, in which 90% or more of the ragweed plants were destroyed in three of the five boroughs; pollen counts done during the season were virtually identical in all five.[4]

Ragweed is, of course, the most common cause of hay fever and is associated with an incredible loss of man hours from work each year. Many is the patient who travels to areas where the pollen count is low, just to avoid having symptoms. There is no ragweed anywhere in the world except the United States and portions of Canada and Mexico.

While molds are present through the year, the most important ones predominate from April until November. An old wives' tale has ragweed ending with the first frost, when actually it ends a good month earlier. It is Alternaria—the kingpin of the molds—that meets a sudden demise with the first frost. Alternaria-sensitive patients are in their glory when there is snow on the ground, and might be ideally suited to man the radar stations in Alaska. In September and October, Alternaria counts are at their highest, perhaps associated with the burning of leaves. Other molds such as Hormodendrum and Helminthosporium are associated with the warmer weather, as opposed to Penicillium and Aspergillus which are household molds.

Summer also means the return of our much maligned associates—bugs. Insects cause allergic symptoms by two methods: the bite or sting of the Hymenoptera group, and the inhalation of particles of the bodies of various insects. Wasp stings are the oldest known form of allergy, as they caused the death of one of the pharaohs in ancient Egypt.[5] Bees, wasps and hornets account for many deaths in this country, and those sensitive to them should carry special treatment kits at all times; a few minutes delay in the administration of epinephrine to such a patient, might be the difference between life and death. Inhalation of particles of insects may cause sneezing and wheezing in a susceptible individual.[6] Both of these forms of insect allergy may be benefitted by hyposensitization.

The insect recognizes no professional bounds. He is as apt to bite the physician as the patient. So this season, beware of bugs. And beware, too, of poison ivy. That pleasant stroll through the woods and underbrush with the Boy Scouts might turn into a

(Concluded on following page)

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nightmare for the botanically uninitiated in the causes of rhus dermatitis (poison ivy, poison oak and poison sumac). Although you may have been careful, your dog may not have noted that it wasn't clover he jumped through, but poison ivy. His return to your side may give you the rhus dermatitis that you so carefully avoided. That heavenly campfire may be emitting particles of rhus oil to produce an airborne contact dermatitis of the exposed areas of the body.

Another fascinating, but rather infrequent type of summer allergy is physical allergy. Some people sneeze on exposure to sunlight, while others break out in rashes, usually on the exposed parts of the body. These rashes may well follow the administration of various photosensitizing drugs, e.g. demethylchlortetracycline.[7] Another form of physical allergy and one that may be lethal in the summer, is cold allergy. Yes, I mean cold allergy, not heat allergy. The cool dip on a hot day with its consequent sudden chilling of the body, may be the coup de grace for a cold sensitive patient.[8] It is customary to write "heart attack" on the death certificate, even though the victim may have been an 18-year-old boy who looks like a Greek god.

Lest the reader be depressed by this saga of afflictions associated with the warmer months, perhaps he should remember that it is also a time for swimming, baseball, lying in the sun and taking that long-planned vacation. So let's all join in a chorus of "In the Good Old Summertime," as we sneeze, wheeze and scratch. Be careful of your suntan lotion, however; it may cause you a contact dermatitis.

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with the Communicable Disease Center, USPHS.

Promotion of immunization has been a continuing part of the AMA's health education program. Campaigns aimed at thwarting polio, smallpox and tetanus were forerunners of the current, broad-based program.

"While the major thrust of the new campaign is aimed at immunization against measles," said Fred V. Hein, MD, director of the AMA's Health Education Department, "we must not relax our efforts against other diseases preventable by immunization."

Dr. Hein noted that the means are available not only to eradicate measles in the foreseeable future, but also to eliminate the deaths from tetanus that occur each year, to prevent the outbreaks of diphtheria and polio that crop up from time to time, and to bring other communicable diseases under better control.

Measles is still a universal illness. Approximately 90% of the adult population in the US has had measles; but, because of its prevalence, a general apathy to the disease has arisen. Yet its side effects and complications make measles more serious than the general public realizes. An average of one death occurs in every 10,000 cases.

With the licensing of three different measles vaccines in the past four years, some inroads have been made. The number of cases reported to the USPHS, which estimates that only about 10% of the actual number of cases are reported, dropped from 458,083 in 1964 to 202,886 in 1966. The figure was a 21-year low.

H. Bruce Dull, MD, assistant chief of the Communicable Disease Center in Atlanta, estimates that from 18 to 20 million measles-susceptible children have been vaccinated in the past four years as the result of "excellent performances" by the medical profession and state and local health departments.

Among the concentrated efforts carried out by medical societies last year were a statewide "End measles once and for all" campaign conducted by the Rhode Island Medical Society and similar programs conducted by medical societies and other members of the health team in metropolitan Pittsburgh and Detroit. In the special Rhode Island campaign 34,458 children (66.9% of the measles-susceptible population) were immunized. In Detroit more than 171,000 children were immunized, and in Pittsburgh 52,241.

As Dr. Dull points out, however, only about 45% of susceptible children (ages 1 through 8) have so far been immunized.

Still to be protected are approximately the remaining 55%—six million youngsters who will enter kindergarten or grades one and two this year and an estimated four million more who will reach age one during 1967.

Chief objectives of immunization programs urged by the AMA are:

1. Acquaint the public with available immunizations, their values and at what times in life they should be obtained.

2. Encourage people to seek immunization according to recommended schedules.

3. Encourage physicians to step up their efforts to maintain a high level of immunization among their patients.

AMA Publications Available

Facts on Quacks, a complete source book touching every aspect of health quackery, is now off the presses, the American Medical Association has announced.

In development for 18 months, the new publication is considered a major instrument in the AMA's program of alerting the public to the evils of quackery. A 32-page, two-color, illustrated booklet, it is written in question and answer form, covers facts on health quackery in such fields as arthritis and rheumatism, cancer, nutrition and weight reduction, over-the-counter drugs, alcoholic nostrums, health books and pamphlets, epilepsy, mental health and retardation, cosmetics, baldness, rejuvenation and sex stimulants. One section advises the reader what he should do if he suspects health quackery activities in his community.

"Never before has there been any book like this," Doyl Taylor, director of the AMA Department of Investigation, says. "It should be placed in every reference library in the country and certainly in every medical library . . . individual physicians should place copies in their waiting rooms."

Facts on Quacks is being published by the AMA in full cooperation with such governmental and voluntary agencies in the health field as the



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National Health Council, the Food and Drug Administration, the National Better Business Bureau, the Post Office Department, the Federal Trade Commission, the American Cancer Society, Inc., and The Arthritis Foundation.

Requests for the booklet should be directed to the Order Department, AMA 535 North Dearborn Street, Chicago, Ill. 60610. Single copies, 30¢; 50-99, 28¢; 100-499, 25¢; 500-999, 23¢; 1,000 and over, 20¢.

Obtainable from the same source is another new AMA publication, *The Look You Like*, a 129-page paperback with information on the use and abuse of cosmetic preparations gleaned from the *Today's Health* question-and-answer column of the same name. Answers to all questions appearing in this column are written with the help of outside consultants in industry and the medical profession who are considered authorities on the question at hand. Subject matter is reviewed by members of the Committee on Cutaneous Health and Cosmetics.

Retail sales of cosmetics are expected to surpass the $4 billion mark this year. Considering the extensive number of people who use cosmetics and the wide range they have to select from, it is readily apparent that occasional reactions to cosmetic programs will occur. The new book was prepared as a guide to help individuals avoid or overcome such problems.

Single copies are $1.70 in the US, its possessions, Canada and Mexico ($2 elsewhere). There is a special rate of 90¢ for medical students, interns and residents.

Cases on Anesthesia, a collection of court decisions relating to physican or hospital liability arising out of the administration of anesthesia, is now available to any physician upon request.

This most recent in a series of collections of cases, published by the Department of Legal Research, Law Division, AMA, covers such medical problems as contraindications, allergic reactions, intubation, explosions or burns and extravasation. Also included are legal topics such as

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The tenth guide in the series *Guides to the Evaluation of Permanent Impairment,* developed by the Committee on Rating of Mental and Physical Impairment, is now available. Entitled *Guides to the Evaluation of Permanent Impairment—Mental Illness,* this guide, like, all the others in the series, has been designed primarily for use by physicians, but is of interest and use to all concerned with the medical, administrative, or judicial aspects of programs for the disabled.

The previously published guides in the series deal with the extremities and back; the visual system; the cardiovascular system; ear, nose, throat, and related structures; the central nervous system; the digestive system; the peripheral spinal nerves; the respiratory system; and the endocrine system.

A limited number of copies of the new guide may be obtained, without charge, upon written request to the Committee at 535 North Dearborn Street, Chicago, Ill. 60610.

Any medical society member interested in current legal developments affecting the medical profession may arrange to receive the semimonthly newsletter, *The Citation.* Published by the Law Division of the AMA, it is directed primarily to attorneys for medical societies, medical society executives and members of medicolegal committees, but many other physicians have been added to the mailing list at their request.

In the Jan 13, 1967 issue of *The Citation,* eight court decisions involving physician or hospital liability were reported as were 19 other court decisions on subjects such as licensure, hospital staff privileges, tax problems, osteopathy and fluoridation of public water supplies.

Personal requests for "The Citation" should be sent to the Law Division, AMA, 535 North Dearborn Street, Chicago, Ill. 60610.



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These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever, euphoria and dysmetria.

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Maryland State Medical Journal
Vol. 16, No. 4
April, 1967

PRESIDENTIAL EDITORIAL



Richard D. Bauer, MD
President, Medical and Chirurgical
Faculty of the State of Maryland
April 1967-April 1968

As I sit at my desk pondering these changing times in which I take over the presidency of the Faculty, two problems seem to be of equal primary importance. The first of these is not new—indeed, it has been a matter of concern for several years. I refer to the effect of the "welfare state" on our mode of life. The second has to do with the role of the general practitioner in this day of "super-specialization" and changing concepts of medical practice.

I hasten to mention that the opinions expressed here are my own and do not necessarily reflect Faculty policy.

History tells us that a nation based on a widespread welfare foundation is a nation in trouble, economically and morally. A welfare state is a bureaucracy that fosters laziness and nonproductivity. There is a striking contrast in our own national history illustrating this point so well that it seems incredible people can overlook it. Consider, on the one hand, the Emancipation Proclamation of the year 1862. In freeing the Negroes from slavery, the act allowed them to better themselves as best they could. They were given the right to certain basic freedoms, such as free-

dom to choose their type of work, to educate themselves as much as possible, and to provide for their own old age. Theirs has been a long hard struggle over the past hundred years, but we are witnessing the emergence of a powerful citizenry that numbers among its people leaders in almost every field.

Now consider the American Indian. This once proud and vital race represents the ultimate welfare state. They live on reservations and approximately 13,000 Federal workers look after them, roughly one worker for every 30 Indians. What is their plight? They have lost their pride and their initiative. They have become lazy, indigent and nonproductive.

This is why thinking men should harness the welfare philosophy before it is too late. This is why we must be extremely careful of who receives welfare benefits. True, we can and must take care of those who cannot take care of themselves—we always have. Something is radically wrong, however, with a system that allows welfare support of those who can take care of themselves but will not do so.

In regard to the second question, that of the role of the general practitioner, we must put aside all personal philosophy and prejudice and view the problem objectively. It is interesting to watch what is happening now. Banks, insurance companies, pharmaceutical houses and the medical fraternity are being flayed in the press and in Congress. Each of these groups has done a good job and, justifiably, has a good self-image. Unfortunately the image one has of oneself is not always the same as that seen by others. There are thousands of restless eyes that may see things a little differently.

We, as physicians are not looked upon by people the way we used to be. We have failed to realize that the circumstances of medical practice have changed. Our present clinicians are much better trained than they used to be, but there is something lacking. It is obvious from many meetings and from the Millis Report that extreme specialization and the slow disappearance of the family doctor is not satisfactory. There is talk now of educating a "primary physician." To my way of thinking, medicine has an obligation to keep intact the ratio of general practitioners to specialists. Specialization is very important, but so is general practice. People need more than science. The family doctor is a friend, an advisor and a "Dutch uncle." People do not always pay him, but they love him. An explanation of his secret is given by Balint:

> The most frequently used drug in general practice is the doctor himself and this is a drug without directions as to dosage, frequency of administration or undesirable side effects. We know that the doctor himself is an extremely powerful drug and that those who use it relieve more suffering than has yet been recorded by the most powerful drug in the pharmacopoeia. The family doctor knows this and he prescribes himself in generous doses.

Actually, this is the secret of the whole practice of medicine no matter what position one occupies—student, teacher, specialist, administrator or family doctor.

Francis J. Braceland, MD, recently spoke of the tremendous "information explosion" which we have seen in medicine for a number of years. We have been inundated with new information at such a rate that it is difficult to keep up with it all. This is what has led to the extreme in specialization. It will not cease; there will be even more innovation in the future. There will be many changes but this is as it should be because all of life is change. As Edna St. Vincent Millay wrote:

> All creatures to survive, adapt themselves to the changing conditions under which they live.
> If they can grow new faculties to meet the new necessity, they thrive; otherwise not.
> The inflexible organism, however much alive today, is tomorrow extinct.

We may expect change, and must be prepared for it. We must be adaptable to changing concepts of public welfare, but within the bounds of common sense, and we must also be adaptable to changing concepts of medical treatment, but within the framework of a constant, workable ratio of general practitioners to specialists. Changes may at times be vexatious, but they are necessary.

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TURN TO PAGE 157

IATROGENIC INFECTIOUS DISEASE PROBLEMS, WITH PARTICULAR REFERENCE TO PYELONEPHRITIS

CHRISTOPHER M. MARTIN, MD
Professor of Medicine and Pharmacology, Georgetown University School of Medicine
Director, Georgetown University Medical Division District of Columbia General Hospital

As physicians, all of us have a basic responsibility both to treat and to prevent disease. At the same time, we also bear a very serious responsibility to obey the injunction of Hippocrates to do no harm.

These principles have particular bearing on the problem of pyelonephritis. In the light of information accumulated over the last ten years or so, and following upon the fundamental observations of Dr. Edward Kass at Harvard Medical School in the mid-1950's, we now know that pyelonephritis is the second most common infectious disease in the United States, exceeded in frequency only by acute and chronic respiratory tract infections. Moreover, we now know—much to our dismay—that the vast bulk of pyelonephritis in the United States today is caused by physicians.

This comes as quite a startling realization to many physicians who have been practicing medicine of high quality for many years; yet, the evidence is overwhelming.

Our interest in this field began in 1961, following a review of cases of bacteremia at the Jersey City Medical Center, in New Jersey; it was found that despite all the publicity and interest that had been given to staphylococcal and other gram-positive coccal bacteremias, by far the most common bacteremia—indeed, about half of all bloodstream infections with sepsis—were due, instead, to gram-negative rods.

Review of the charts of 102 patients with gram-negative rod bacteremia in 1960, 56% of whom died, revealed that in 81 of them, pyelonephritis was the source of bacteremia. Moreover, 78 of these 81 patients had had some form of urinary tract instrumentation either prior to the hospitalization in which the bacteremia occurred, or during that hospitalization. The most common form of associated instrumentation was indwelling urinary tract catheterization.

These observations were consistent with the published data of many investigators, particularly Dr. Paul Beeson, then professor and chairman of the department of medicine at Yale. You will recall that Dr. Beeson wrote a famous editorial in the American Journal of Medicine entitled, "The Case Against the Catheter,"[1] in which he marshalled all the evidence indicting catheters as major causes of infection. He came to the conclusion that the indwelling Foley catheter was a

Presented at a combined medical program of St. Joseph Hospital and the Baltimore County Medical Association, at St. Joseph Hospital, Baltimore, Feb 4, 1967.

dangerous if not lethal instrument, and that it should be abolished.

Although we sympathized with this view, we nevertheless recognized that catheters cannot be abolished; they are obviously of extraordinary importance, comparable to the hollow needle in medicine. They are an integral part of the weaponry of surgeons, internists, gynecologists, and obstetricians. We concluded that there must be a better catheterization method than the standard Foley catheter for patients who had problems with micturition and who required indwelling catheterization. As a result, we set up a controlled trial of old and new catheter technics in gynecologic patients at the Jersey City Medical Center.

The patients in the trail were 75 women consecutively undergoing gynecologic surgery, who would require post-operative indwelling urinary catheterization. The patients were randomly assigned to one of four catheter groups; assignment was on the basis of the two terminal digits of the patient's hospital number. In other words, the physician taking care of the patient had nothing to say about which catheter was going to be used.

The four kinds of catheter technics studied included:

1. The straight Foley catheter with standard good catheter technic.

2. A straight Foley catheter with systemic chemoprophylaxis in the form of chloramphenicol, 2 gm a day. (The large majority of urinary-tract pathogens were sensitive to chloramphenicol at that time [1961].)

3. The so-called "three-way catheter," with a constant bactericidal rinse of the catheterized bladder. (The "three-way catheter" is essentially a Foley catheter with an extra lumen, through which one runs into the bladder a constant slow drip rate of an antibacterial solution; in this instance, the solution was ¼% acetic acid.)

4. Another three-way catheter group, with a bactericidal rinse consisting of a solution of neomycin and polymyxin, in low concentration.

The results of the study are shown in the Table. These are the infection rates in women proved non-bacteriuric prior to catheterization. As shown by many other authors, the infection rate in women with Foley catheterization (Group 1) was 11/11; in the women who had Foley catheters with chloramphenicol chemoprophylaxis, the infection rate was 10/13 (77%)—not significantly different from Group 1. Those having a three-way catheter with an acetic acid bactericidal rinse had an infection rate of 1/6; none of the 10 women on a three-way catheter with the neomycin-polymyxin rinse acquired infection.

The infection rate in Group 4 is significantly different from that in Groups 1 or 2; the odds against this difference occurring by chance are over 1,000 to 1.

There was an interesting fifth group that emerged from the study. These were patients of private physicians who objected to their entering the trial, and instead placed them on Foley catheters with penicillin-streptomycin chemoprophylaxis. These patients' bacteriology was also followed, and 5/7 became infected. This infection rate is not significantly different from that in either the Foley or Foley-plus-chloramphenicol group.

As a result of this study and the concern about the rising incidence of gram-negative rod bacteremia at this hospital, the medical staff in late 1961 decided that the time had come to prohibit further use of the Foley catheter, and to recommend instead, as a routine catheter technic, the so-called

INCIDENCE OF BACTERIURIA AFTER INDWELLING CATHETERIZATION IN 47 NON-BACTERIURIC PATIENTS

	No. of Patients		
Catheter Group	Total	Acquired Bacteriuria	Infection Rate
1. Foley	11	11	100%
2. Foley + chloramphenicol	13	10	77%
3. 3-way + acetic acid rinse	6	1	17%
4. 3-way + neomycin and polymyxin rinse	10	0	0
Foley + penicillin and streptomycin	7	5	71%

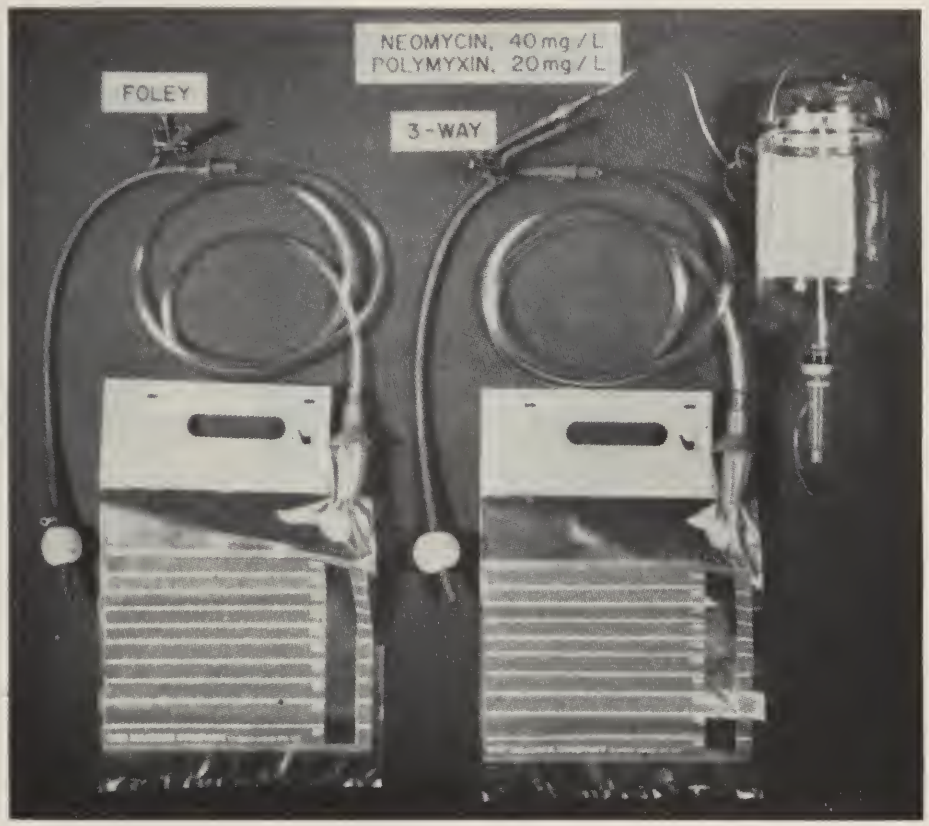


Fig 1
Foley catheter (left) and three-way catheter with neomycin-polymyxin rinse (right).

three-way catheter with constant rinse of the bladder with dilute neomycin and polymyxin.*

In the year that followed announcement of this policy, the Foley catheter was, of course, used to some degree. On the whole, however, the hospital staff switched over to the three-way catheter technic.

The three-way catheter and the conventional Foley catheter are shown in Figure 1. The concentrations of neomycin and polymyxin chosen were designed to produce non-toxic but reliably bactericidal levels of each antibiotic in the urine-rinse mixture in the bladder at all times.

Subsequent studies in larger populations demonstrate that the three-way catheter is by no means perfect. No catheter system is—there is always a calculated risk. But it is clearly much safer than a Foley catheter. The infection rates on conventional open Foley catheters, as observed by many authors, run to about 96% after four or five days; in contrast, the infection rate with the three-way catheter plus neomycin-polymyxin constant rinse is about 4% after five days, and about 6% after ten days. The longer catheterization is prolonged, the greater the risk of becoming infected, no matter what catheterization technic is used.[2]

In any event, after a year's experience in substitution of this newer catheter technic, we attempted to detect any influence of the change on the incidence of disease at the hospital. We therefore made a comparative study of the incidence of bacteremias at the Jersey City Medical Center in 1962, the first full year of three-way catheter experience, with that in 1960, the last full year of standard Foley catheter usage.

Figure 2 shows some basic information about the hospital in the two years. The numbers of admissions and the overall mortality rates were about the same in 1960 and 1962. The number of

* 40 mg neomycin and 20 mg polymyxin per 1000 ml isotonic saline per day.

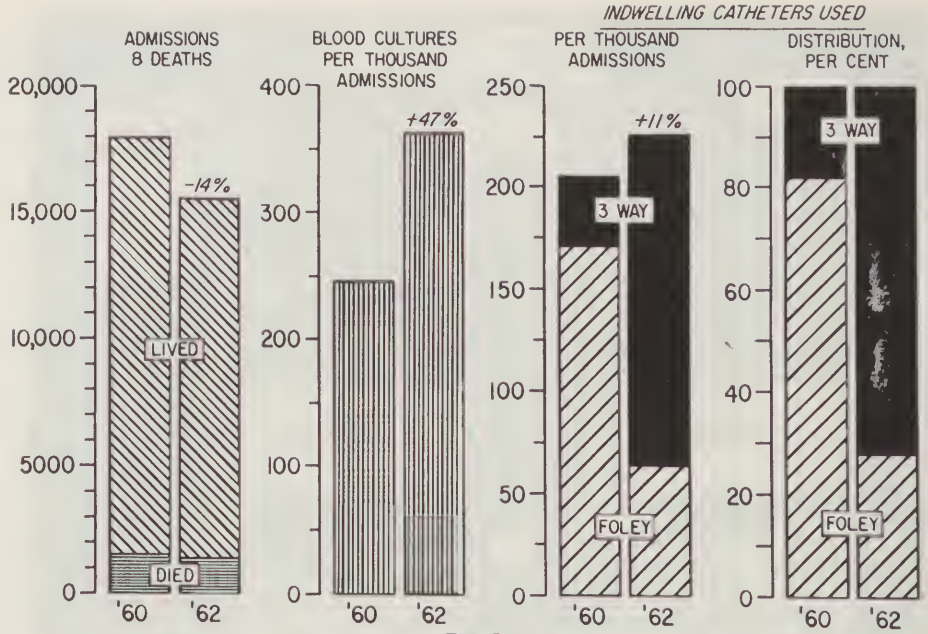


Fig 2
Admissions, blood cultures, and catheter usage at the Jersey City Medical Center in 1960 and 1962.

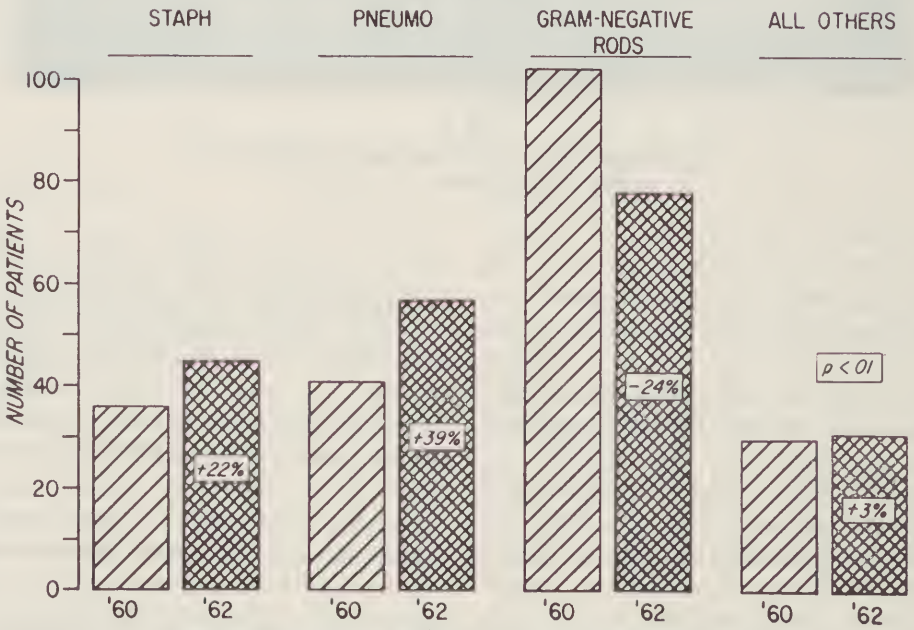


Fig 3
Bacteremias at the Jersey City Medical Center in 1960 and 1962.

blood cultures taken went up, however, in 1962, reflecting the fact that the Surgical Services were taking more blood cultures than previously.

Figure 2 also shows the changes in the types of catheters used. There were few three-way catheters used in 1960; in 1962, however, they constituted 72% of all the catheters used.

Figure 3 shows the numbers of bacteremias of various kinds in the two years. Consistent with the increased numbers of blood cultures taken, there was a 22% rise in staphylococcal bacteremias in 1962; a 39% rise in pneumococcal bacteremias;

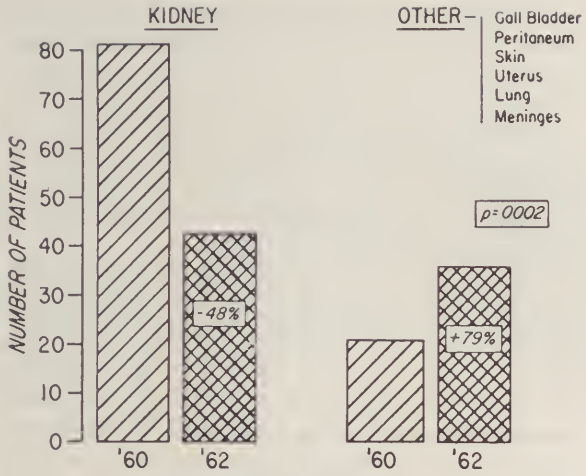


Fig 4

Sources of gram-negative rod bacteremias.

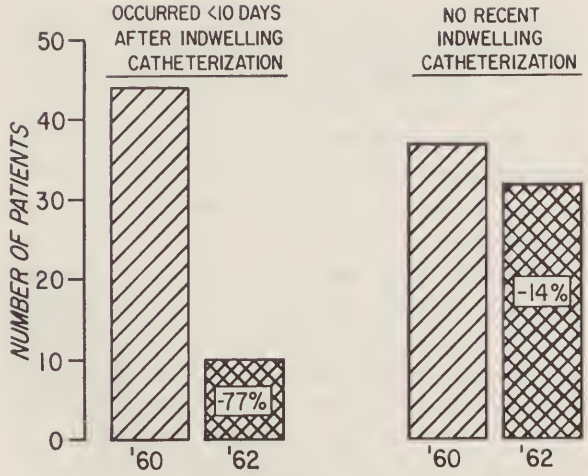


Fig 5

Gram-negative rod bacteremia of renal origin.

and a 3% rise in miscellaneous forms of bacteremia. Gram-negative rod bacteremias, however, declined by 24%.

This difference in distribution in types of bacteremias in 1962, as compared with 1960, could have occurred by chance less than once in a hundred times.

When we focus on gram-negative rod bacteremias specifically (Fig 4), we find that there was a rise of 79% in the incidence of gram-negative rod bacteremias arising from non-renal sources—ie, complicating cholangitis, peritonitis, infected decubitus ulcers, septic abortions and the like—and reflecting the fact that the surgeons were really on the alert in 1962 to bacteremias and were taking a good many more blood cultures. On the other hand, there was a 48% decline in numbers of gram-negative rod bacteremias complicating pyelonephritis. The odds that this change could have occurred by chance are about 5,000 to 1.

The influence of indwelling catheterization is shown in Figure 5. There was only a non-significant 14% drop in bacteremias complicating cases of pyelonephritis not associated with recent instrumentation. In contrast, there occurred a highly significant 77% decline in gram-negative

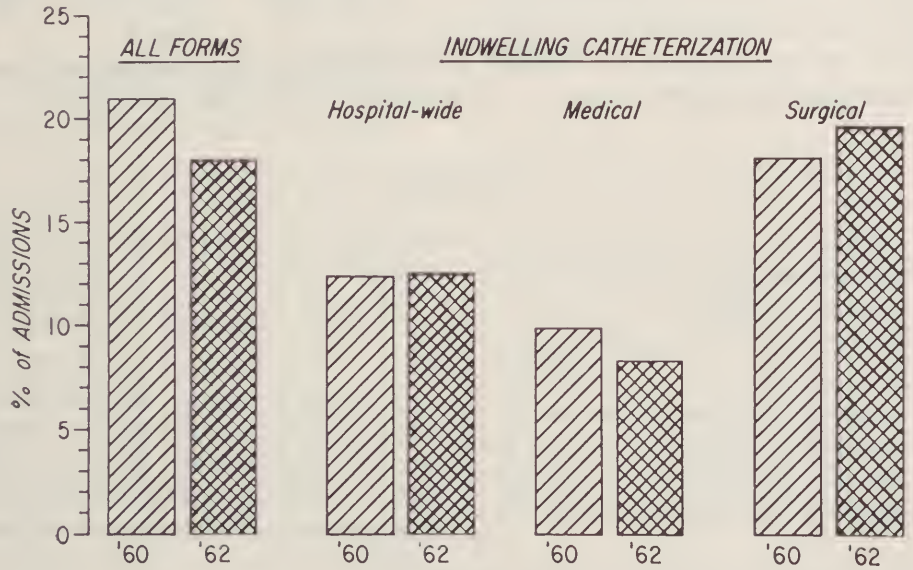


Fig 6

Urinary tract instrumentation at the Jersey City Medical Center in 1960 and 1962.

rod bacteremias occurring within 10 days of indwelling catheterization. The probability that this difference between 1960 and 1962 could have occurred by chance is about 1 in 1000. We therefore have clear evidence that the substitution of the new catheter technic was associated with a marked decline in numbers of gram-negative rod bacteremias.

Of course, there are other factors to be considered. For example, were there fewer bacteremias in 1962 because fewer patients were catheterized? The data in Figure 6 demonstrates that this is not the case—that indwelling catheter usage was virtually the same in the two years. Examination of this and other such relevant factors failed to reveal anything other than the newer catheterization technic that could have accounted for the decline in numbers of catheter-associated gram-negative rod bacteremias.

The number of deaths from all gram-negative rod bacteremias (Fig 7) fell from 57 in 1960 to 32 in 1962, a 44% decline. This difference is due primarily to the decline in numbers of deaths from bacteremias of renal origin—from 46 to 13. And this difference, in turn, is due primarily to the decline in numbers of deaths from catheter-associated bacteremias—from 33 to 5.

Now if we assume that this experience in Jersey City, NJ, is reasonably representative of what might be expected to happen elsewhere in the United States, we can make some estimates of the possible effects of abandonment of Foley catheters in all American hospitals and substitution of the 3-way catheter technique.

A simple rate calculation suggests that somewhere between 8,000 and 31,000 preventable deaths associated with conventional Foley catheterization occurred in the United States in 1962. It is obvious, therefore, that we have here a major area for effective preventive medicine on the part of internists, surgeons, gynecologists, urologists—indeed, all physicians.

In conclusion, we have here an example of the value of reexamining traditional concepts in medicine, and of asking ourselves whether our therapeutic methods do more harm than good. When we can identify this kind of harm and do something about it, then we will have fulfilled our highest responsibilities as physicians.

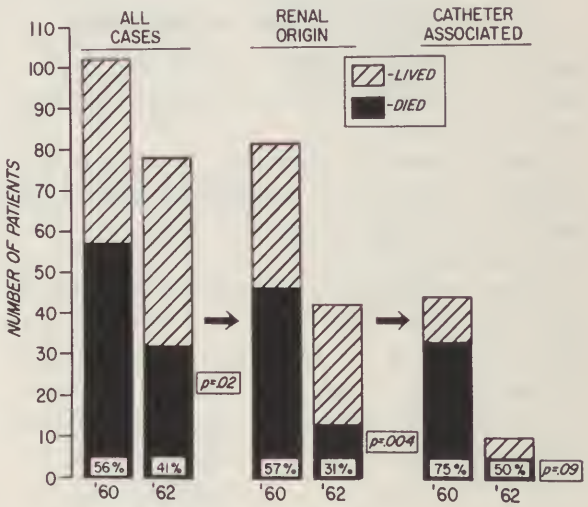


Fig 7
Mortality from gram-negative rod bacteremia in 1960 and 1962.

Discussion

QUESTION: *What kind of unit do you use for your three-way catheter rinse? Are the catheters available from various companies?*

DR. MARTIN: Although one can arrange for one's hospital pharmacy to make up the rinse solution from bulk neomycin and polymyxin, it is much more convenient to purchase the rinse formulation in one cc vials, which are now available from two companies—Burroughs-Wellcome and Upjohn.

Three-way catheters are available through the major catheter manufacturers, American Cystoscope Makers, Inc., and the Bard Company. These catheters cost a few cents more than standard Foleys.

QUESTION: *How fast is the irrigating fluid run in?*

DR. MARTIN: At a rate of about one liter per day, or about 40 cc per hour. The flow rate is not at all critical. It can be as low as 500 ml per day, or as high as 3,000. In general, one aims to match the patient's approximate endogenous urine output.

QUESTION: *How were these patients prepared for catheterization? And since the subjects in*

your controlled study were all women, would it be possible that we would be getting a lower incidence of infection in males?

DR. MARTIN: First, in all these catheterizations, the urethra and peri-urethral area were thoroughly cleansed and disinfected, and the catheterization performed with standard aseptic technique. As to the second question: On the basis of our hospital-wide experience in all patients, there would appear to be no significant difference in the effectiveness of the 3-way catheter system in men and in women.

QUESTION: *Were any studies done with different anti-bacterial agents; in other words, neomycin by itself, for instance? How did you show this?*

DR. MARTIN: That is an interesting question. We have looked at quite a few antibacterial substances as possible substitutes for neomycin-polymyxin. As Dr. Kass originally showed, dilute acetic acid possesses comparable activity. Unfortunately, dilute acetic acid is impractical, because the rinse flow must be maintained at just the right rate; too fast a flow gives rise to hemorrhagic cystitis, and too slow a flow (with consequent inadequate lowering of urine pH) produces ineffective antibacterial conditions. Other substances that we have tried include organic iodine, nitrofurazone, and things of this nature. These all cause a high incidence of hemorrhagic cystitis. It would appear that the neomycin-polymyxin rinse is quite bland and virtually non-toxic.

QUESTION: *This method you mentioned is for hospital patients. How about ambulatory patients who need indwelling catheters?*

DR. MARTIN: The method can be adapted to ambulatory patients, but with some difficulties. There is no single set of equipment one can purchase to do the job. One can, however, put it together by hanging from the waist a bag of the type used for collecting T-tube drainage, and using this for the inflow rinse fluid; an outflow collection bag can then be strapped to the patient's leg. One can also reduce the volume of rinse flow from a liter a day to 250 ml per day by simply using a solution four times as concentrated, but running it in at only one-fourth of the usual rate.

I would say that this technique is primarily designed for hospital patients; it is most useful in those patients who require relatively brief (1- to 10-day) catheterizations.

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"THE SINISTER GARDEN"

Please don't eat the buttercups—or the iris, or the rhododendron. And don't munch on the mistletoe berries, either.

This is part of the information in a booklet distributed to poison control centers, hospital accident wards, pediatricians, general practitioners and pharmacists by field representatives of Wyeth Laboratories during National Poison Prevention Week, March 19-25. Entitled *The Sinister Garden,* the booklet contains drawings of 56 different plants found in flower and vegetable gardens, in fields or as ornamental plants in the home. The toxic parts of each plant are listed along with the symptoms that may occur when those parts are ingested.

The Sinister Garden points out that parts of *edible* plants may also have toxic effects. For example, the potato itself is edible, but the sprouts, leaves and stems of the potato plant "may cause mental confusion, cardiac depression and clammy skin." And rhubarb plants can be cooked for the dinner table, but rhubarb leaves may cause vomiting and severe abdominal pains.

Other plants, parts or all of which are poisonous, include cherry and oak trees, privet hedge, wisteria and mountain laurel.

From a Wyeth Laboratories news release, March 1967.

INFLUENCE OF SPLENECTOMY ON CHILDHOOD INFECTIONS

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Since the report in 1952 of two infant deaths from septicemia following splenectomy,[1] there has been natural concern that removal of the spleen would decrease resistance to bacterial infections in young children. A number of retrospective studies have attempted to determine the effect of splenectomy on incidence of infection, but it has been practically impossible to compare patient groups because disease processes within the groups varied so widely.

We have recently reviewed the post-splenectomy courses of 51 young children who were treated at The Johns Hopkins Hospital between 1928 and 1964. In addition, we have been studying the effect of splenectomy in small animals on experimentally induced infections. The discussion which follows concerns the function of the spleen in the immunologic mechanism and is based upon data from the patient review and these experimental studies.

Clinical Review

Fifty-one children between the ages of four months and ten years were randomly selected from the splenectomy files of The Johns Hopkins Hospital. It is significant that only one child was under a year of age and only seven were under two years of age. Seventy-five percent of these children were examined by the author or were reported upon by family physicians, with a post-splenectomy follow-up greater than one year. The age distribution of these children is shown in Table 1.

Indications for splenectomy are listed in Table 2. Five disease categories were selected arbitrarily to reflect in descending order the degree of hematologic involvement present in each case. It will be noted that the largest single group of splenectomies was for congenital spherocytosis.

An attempt was made to assess the incidence of infections before and after splenectomy with a full realization that this was largely a subjective evaluation. The highest incidence of infection occurred in the last three groups (Table 2), in which there were significant hematologic abnormalities, but the incidence of infection *before* and *after* splenectomy did not differ significantly.

There were no intraoperative deaths, but five patients died in the follow-up period. Two of these patients died with infections, as noted in Table 3. One was a three-year-old with idiopathic thrombocytopenic purpura (ITP) who died of probable septicemia 23 days after going home from the hospital. The other was an eight-year-old who had empyema following an esophago-jejunostomy for esophageal varices performed three years after her splenectomy. Except for these cases (No. 1 and No. 2 in Table 3), infection could not be implicated in the five deaths. Two of the remaining 33 patients continue to have significant hematologic problems requiring

Based on a paper presented to the Maryland Pediatric Society, Nov. 8, 1966.

close medical supervision, but the others lead active, normal lives.

During follow-up studies on this group of post-splenectomy patients and in the course of our review of reported studies on post-splenectomy patients, it became obvious that neither objective nor comparative information was likely to be forthcoming from any human patient group because of serious difficulties in defining a satisfactory control group. We therefore turned to the laboratory where a splenectomy model was already under study in small animals.

Table 1

SPLENECTOMY IN 51 CHILDREN

(The Johns Hopkins Hospital, 1928-1964)

Age (Years)	Number of Children
<1	1
1-2	6
2-4	9
4-6	9
6-8	13
8-10	13
Total	51

Age Range: 4 mos-10 yrs
Average Age: 6.1 yrs

	Children	
Sex	No.	%
Male	32	63%
Female	19	37%
Total	51	100%

Experimental Neonatal Splenectomy

Splenectomy and sham splenectomy were carried out in newborn mice in which the spleen was removed in half the litter, and in the other half the spleen was exposed but not removed.[2] Each mouse was then homografted with skin from an unrelated species to test the immune responsiveness of the two groups of experimental mice. In other litters splenectomy and sham splenectomy were carried out in mice three, six and nine days of age.

All mice in the four groups rejected skin homografts at normal times and with the usual characteristics of strong immunologic reactions.

Table 2

INDICATION FOR SPLENECTOMY

	Children		Average Age
	No.	%	(Years)
Trauma	11	21%	7.7
Spherocytosis	18	35	5.4
ITP	8	16	6.3
Hypersplenism	6	12	4.8
Other	8	16	6.0
Total	51	100%	

Using the same experimental model, splenectomized and sham splenectomized mice were injected intraperitoneally with cultures of Escherichia coli. Gram-negative bacterial peritonitis developed in all mice. There was no statistical difference in survival rates in the two groups.

Review of Reported Experience with Post-Splenectomy Infections

In their important clinical observations in 1952, King and Shumacker[1] emphasized the facts that they were concerned about post-splenectomy infections *only* in the infant age group and that their experience was confined to five infants. Parts of their report have been widely used out of

Table 3

CAUSE OF DEATH AFTER SPLENECTOMY

1. 3 yrs (ITP)—Died 23 days after discharge. Acute onset of high fever and delirium. DOA—no autopsy (septicemia??)
2. 7 yrs (Pancytopenia)—Died 13 days after splenectomy. Hemorrhagic diathesis.
3. 8 yrs (Extrahepatic portal hypertension)—Died 3 yrs after splenectomy from empyema and massive G-I bleeding following esophagojejunostomy.
4. 10 yrs (Biliary cirrhosis)—Died 5 yrs following splenorenal shunt (intestinal obstruction??)
5. 5 yrs (Hypoplastic anemia)—Died 1 yr after splenectomy from subdural hemorrhage after blow to head.

context to suggest that splenectomy in any child for any reason carries a significant risk of serious infection. A limited review of our experience at Johns Hopkins and an analysis of reported cases of post-splenectomy infections do not support this thesis.

The five infants reported by King and Shumacker were in a series of 100 splenectomy patients. In none of the others was there an increased incidence of infection. In 1951 Gruber and associates[3] reported a premature infant with ITP and a bleeding diathesis who succumbed to septicemia after splenectomy at 14 hours of age. This baby was obviously in dire straits at birth and had an emergency procedure under less than optimal circumstances. In 1954 Evans and associates[4] reported one serious infection in a large series of patients with hypersplenism. It occurred in a two-month-old baby with spherocytosis; the child recovered. In the same year Simpkiss and Cathie reported a septicemia death in a 14-month-old ITP patient in a group of older ITP patients who had no infections.[5] Two infants in the series by Walter and Chaffin in 1955 had severe hematologic disorders and died of terminal infections.[6] In the 200 cases reported by Golstein and Gellis in 1956 from the Boston Children's Hospital, only four cases of increased infections were noted after splenectomy.[7] Two were under one year of age. Two had had significant infections prior to splenectomy.

In the carefully studied series of Smith and associates (1957 and 1962), there were 13 patients with an abnormally high incidence of infection after splenectomy.[8, 9] These occurred in more advanced age groups, averaging six years of age. No information is given regarding the total number of children who were splenectomized in this same time interval, however, and the rate of incidence is therefore not known. Significant was the large number of patients in the series with Cooley's anemia (5 of 13) and the fact that four of the five deaths with infection had that disease. Cooley's anemia is known to be associated with an increased risk of serious infections.

Laski and MacMillan, in 1959, compared risks of infection following splenectomy in one group of children with that following appendectomy in a similar group.[10] They concluded that the incidence of infection was the same. There was, however, one serious infection in a four-year-old ITP patient who died after splenectomy. In a post-splenectomy population of 110 children reviewed by Robinson and Sturgeon in 1960, 13 serious infections occurred.[11] However, only one case developed among the 63 children whom they considered "non-disposed by prior disease to increased infections." Six deaths occurred in the other 12 children who averaged 32 months in age and had serious hematologic diseases.

In 1963 Thurman reported two deaths from infection in 73 post-splenectomy children, but he noted the same incidence in a comparable group with hematologic disorders who did not undergo splenectomy. He also carried out studies of gamma globulin levels and response to standard antigens and found no differences in the two blood dyscrasia groups.[12] In 1960 Broberger and associates in Sweden reported 460 splenectomies in children.[13] Fifty-six were under one year of age and 22% of them had serious post-splenectomy infections. The remaining 404 were between one and ten years of age, with serious infection in 11%; the greatest incidence was in patients with thalassemia (Cooley's anemia). These authors also noted that the serum proteins and the immune responses of the splenectomized children were within normal ranges.

These accumulated data suggest that splenectomy under one year of age may increase the risk of serious infection. They also suggest that splenectomy probably increases the risk of infection in a child who has a serious hematologic disease, which in itself predisposes the patient to increased infection. These hematologic diseases are complex and varied but generally fall into the categories of aplastic anemia, Cooley's anemia, thalassemia, hypersplenism (especially when accompanied by a bleeding diathesis), and perhaps idiopathic thrombocytopenic purpura (ITP). There is no evidence that splenectomy for trauma or for congenital hemolytic icterus (spherocytosis) predisposes children to increased risk from infection unless the patient is a tiny infant. In the first few weeks of life there may be many other factors besides removal of the spleen which contribute to increased risk from infections.

Discussion

Controlled double blind clinical studies of splenectomy and infection are practically impos-

sible to obtain despite the notable attempts to do so in a tangential fashion by Laski and MacMillan[10] and by Thurman.[12] No one is willing to deny splenectomy to children who will benefit from the operation in order to compare them with a group who have their spleens removed.

For this reason the more easily controlled animal studies were initiated. Prior experimental work has shown that splenectomy in adult rats (Rowley, 1950[14]) and in chickens (Wolfe, 1950[15]) results in a transient, minimal decrease in antibody response to a standard antigen, but this decrease in antibody titer lasts no longer than a few days. None of the earlier studies attempted to elucidate the role of the spleen in the newborn animal when the total immune mechanism is quite immature. There are theoretical objections to using skin homograft rejection as a measure of immune reactivity because humoral antibodies have not been shown to play a major role in this reaction. Nevertheless it has been repeatedly shown that any means of suppressing the immune response of an animal will result in some prolongation of graft survival. The fact that skin homograft rejection occurred at the same time and with equal vigor in both the splenectomized mice and those with sham splenectomy strongly suggests that the immune reactivity was intact and the same.

The spleen appears to serve as an important component of the total reticuloendothelial system, but there is little to support a unique role for the spleen in overall resistance to infection. An exception to this impression has recently been reported by Ellis and Smith,[16] who have preliminary evidence that the newborn human spleen is the sole source of opsonin, the specific antibody necessary for destruction of pneumococci. It is of great pertinence that the overwhelming infections reported in infancy following splenectomy have been largely due to the pneumococcus. After about six to eight months of age, opsonins are formed by other components of the reticuloendothelial system, namely, the lymph nodes and bone marrow; but prior to that time they are only found in the spleen. Thus it is entirely possible, if this preliminary information is confirmed, that the spleen *does* have a unique function in the newborn in this regard. Fortunately, however, there are very few indications for splenectomy under six months of age.

On the basis of these observations and our own experience, we find ourselves in complete agreement with Thurman's conclusions, in 1963, that when removal of the spleen is indicated, fear of increased infection should not interfere with performance of a splenectomy.[12]

This view has recently been reiterated by Diamond and associates (1965).[17] We would also agree with the editorial comments of Blattner (1957)[18] and Finland (1961)[19] to the effect that infants less than one year of age must be placed under very careful observation after splenectomy and possibly should receive prophylactic antibiotics. Certainly evidence of early infection after splenectomy in infancy calls for immediate, aggressive and specific antibiotic therapy.

Addendum

Since the clinical data was tabulated, two other cases of possible increased susceptibility to infection after splenectomy have been uncovered by Dr. William Zinkham of the Division of Pediatric Hematology at The Johns Hopkins Hospital. One boy had splenectomy for ITP at eight years of age. One year later he had a fulminant pneumococcal septicemia, but recovered. He has been well since. The other boy had splenectomy for ITP in another hospital and was admitted for steroid therapy at Hopkins. As an outpatient, he developed septicemia from a wood splinter wound and died in shock. These two patients should be added to the group with ITP.

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MOTORCYCLE SAFETY LEGISLATION WORKSHOPS

As more motorcycles crowd the nation's streets and highways, the number of related injuries and deaths increases proportionately. In 1965 there were 1,580 motorcycle rider deaths in the US, a 41.3% increase over 1964.

According to the US Public Health Service figures, the death rate for motorcycle accidents in the US, in proportion to the number of vehicles, is twice as high as the comparable rate for automobiles and other motor vehicles.

The number of motorcycles on the roads has increased so rapidly—registration increased by 71% between 1960 and 1964 and by another 31% between 1964 and 1965—that legislation governing the safe operation of these vehicles has lagged behind in almost every state.

With this problem in mind, state licensing authorities, police chiefs, representatives of the motorcycle industry and physicians from eight midwestern states met in Indianapolis last December to participate in a motorcycle safety legislation workshop. The AMA Committee on the Medical Aspects of Auto Safety, which is now making an extensive study of the motorcycle problem in the US, was also represented at the meeting.

Workshop recommendations, made in an attempt to get some rough uniformity in the state laws on motorcycles in view of the increased amount of interstate travel today, included the following:

Motorcycle drivers should be licensed for driving motorcycles—an automobile driver's license should not be the sole qualification for driving a motorcycle.

All motorcyclists should wear helmets which meet the standards recommended by the U.S.A. Standards Institute. The helmet is considered one of the most important safety devices, since most victims in motorcycle accidents sustain head injuries.

Only one passenger, in addition to the driver, should be allowed to ride on a motorcycle, and then only if the motorcycle is properly equipped to carry a passenger.

There should be no more than two motorcycles operating side by side in a single traffic lane.

Rules governing automobile passing should apply to motorcycles.

Motorcyclists should drive with lights on at all times. (This was one of the more controversial topics considered at the workshop.)

A motorcyclist is entitled to the full use of a traffic lane. Auto drivers should respect this right, and not force any motorcyclist off the road.

No motorcyclist under the age of 18 should be given a license unless he has successfully passed an accredited automobile driver's education course, obtained a regular auto driver's license and taken a motorcycle driving test. In no case should a license be issued to anyone under 16 years of age.

From an AMA news release, March 1967.

COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTERS IN MARYLAND

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Both national and local interest in the establishment of comprehensive community mental health centers have increased markedly during the past several years. The impetus for this movement was initiated in part by President Kennedy in a September 1962 address to Congress and the American people, in which he stressed the long-unmet needs f vast numbers of mentally ill and retarded individuals in the United States.[1] The President pleaded for a "bold new approach," which was translated into law with the provision, in 1963, of federal assistance in the construction of comprehensive community mental health centers (Public Law 88-164) and, in 1965, of staffing grants to implement initiation of mental health services.

In the same year, after a period of careful study, the State Board of Health and Mental Hygiene published the *Maryland State Comprehensive Plan for Community Mental Health Services.* Most of the features of the plan were included among the provisions of the Community Health Services Act, passed by the Maryland State Legislature in 1966. It is the purpose of this article to discuss the meaning of community psychiatry in relation to community mental health, to outline the plan for Maryland as enacted by the Legislature, and to describe its features in the solution of mental health problems throughout the State. In order to present as clear a picture as possible, we shall begin with some basic definitions.

Since "community psychiatry" is still in a formative state, many physicians, including even experienced psychiatrists, sometimes find themselves at a loss as to its meaning. It is considered by some to be a branch of psychiatry that deals with the application of *public health techniques* to the problem of mental illness, but others prefer to define it as the application of *psychiatry* to the mental health problems of the community. Either point of view is compatible with the concept of a "community mental health center," which is properly defined as a *program* that provides comprehensive mental health services to meet the total needs of a community. A community mental health center is "more than a synonym for an outpatient clinic or a new name to describe the regionalized unit of a state hospital or a psychiatric unit of a general hospital. It is not necessarily a complex of resources housed in a fine new building."[2]

Such a center embodies several critical concepts requiring delineation. It must be an integral part of the community, with support and participation of its citizens, or it risks the dangers of isolation and of perpetuation of the stigmas of mental illness. The center should provide the comprehensive psychosocial services required in the treatment of patients. Furthermore, the center must ensure continuity of care to prevent fragmentation and inadequate patterns of service.

According to the regulations issued in con-

nection with the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (PL 88-164, referred to above), a community mental health center must provide at least five essential elements of comprehensive mental health services:

1. Inpatient services.
2. Outpatient services.
3. Partial hospitalization services, including at least day care.
4. Emergency services provided 24 hours per day, within at least one of the three services above, and
5. Consultation and education services available to community agencies and professional personnel.

"Adequate services" have been defined as consisting of these five essential elements plus five other components:

1. Diagnostic services.
2. Rehabilitative services, including vocational and educational programs.
3. Pre-care and after-care services in the community, including home visits by professional personnel, foster home placement and half-way houses.
4. Training.
5. Research and evaluation.

History of Community Psychiatry

It would be easy to get the impression that community psychiatry was invented by the psychiatric profession in the 1960s. This is far from true. The ancient philosophers advocated many features of our present programs. Galen favored the treatment of relatives of patients, Hippocrates and Aesculepius recommended the "open door." The Belgian Gheel family care system for psychiatric patients was begun in the 12th century. Many other enlightened methods of modern care were features of European and American hospitals in the 19th century.

The modern community psychiatry movement, which has developed so rapidly within the past decade, was preceded by half a century of greatly increased awareness of the relationship between mental illness and the social environment. Some psychiatrists call attention to the role of Sigmund Freud in introducing the concept of the important relationship between illness and early experience in the family. There is general agreement that Adolf Meyer, who stressed the importance of studying circumscribed units of population, was an important forerunner of community psychiatrists. He was interested in the dynamic and social factors leading to mental illness.

The early years of the 20th century also saw the beginning of psychiatric social work, a profession initially introduced by psychiatrists in an effort to maintain the liaison between patients and community. Arousal of public interest by Clifford Beers, who wrote *The Mind that Found Itself*, and the subsequent development of the Associations for Mental Health, deserve mention as significant influences on this nation. The late 1920s and 1930s saw the development of child guidance clinics that employed teams of psychiatrists, psychiatric social workers, and psychologists working together with children and their parents in the interest of prevention and treatment of emotional disturbances of childhood.

In the 1940s and 1950s community psychiatry received a tremendous impetus with the advent of World War II and with certain other developments, listed here in chronological order:

1. The Marlborough Program, begun in 1938, was developed during World War II in an English hospital under the direction of Joshua Bierer. Its key points were a day care center, a night care center and an after-care rehabilitation center.

2. The Therapeutic Community, a system developed in England during World War II by Dr. Maxwell Jones, introduced the modern *open door policy*. With the doors to the hospital unlocked whenever possible, patients were again treated humanistically and with respect. They were encouraged to participate in creating a therapeutic environment under the supervision and counsel of the hospital staff. These were either new or rediscovered-old features of hospital treatment which soon spread widely in the United States.

3. The Amsterdam Program, developed by Querido after World War II, was an emergency service involving a home visit by the psychiatrist in an attempt to manage the patient with

medication and support until a bed was available in a hospital. It soon became clear that the technique often eliminated the necessity for hospitalization altogether.

4. The National Mental Health Act, passed by Congress in 1946, was partly the result of concern over the fact that one out of every eight young men examined for the armed forces had been rejected on grounds of emotional instability. The Act provided grants to the states for developing mental health programs outside of state hospitals. It also provided for the establishment of the National Institute of Mental Health (1949) as headquarters for the new federal program.

5. The 1953 report of the World Health Organization's Committee on Mental Health emphasized the need for community treatment of the mentally ill. Stating that the need to provide more beds in mental hospitals was overemphasized to a point of neglect in the development of services that would reduce the need for admission, the Committee recommended that community mental hospitals provide outpatient and part-time treatment, rehabilitation services, research, and community education programs.

6. New tranquilizing drugs, introduced in 1955, gave tremendous momentum to the community psychiatry movement, for many patients previously not amenable to either psychotherapy or milieu therapy became responsive to treatment, and could be discharged from hospitals and treated within the community.

7. The Mental Health Study Act, passed by Congress in the same year, resulted in the creation of the Joint Commission on Mental Illness and Health under the chairmanship of Dr. Jack Ewalt.

Action for Mental Health, the report of the Joint Commission, was published in 1960.[3] It stressed the need for changing the locality of treatment of mentally ill patients from the large outlying state hospitals to the communities in which they lived. This eventually led to President Kennedy's historic address and to the passage of Public Law 88-164 in 1963. As already mentioned, the purpose of this law was to make possible the construction of comprehensive community mental health centers in order to keep patients in touch with their families and thus avoid a prolonged break with their normal social environment. At the present time many states are engaged in developing such centers. Some very good ones are already in existence—examples are the Massachusetts Mental Health Center and the San Mateo County Mental Health Services in California, each with its characteristic programs patterned to meet differing local needs. Examination of existing models of community mental health centers demonstrates the uniqueness of each individual community and the desirability of modifying programs to accommodate differences.

The Methods of Community Psychiatry

Community psychiatry covers a number of methods of treatment and prevention, some of which are very old, some of which have come along in fairly modern times, and some of which are extremely new.[4,5] These will be outlined here. Generally speaking, topics 1, 2 and 3 below correspond, in inverse order, to the tertiary, secondary, and primary remedial and/or preventive techniques of public mental health. Tertiary techniques are aimed at reducing the incidence of residual defect, secondary techniques at reducing the prevalence of mental disorder through diagnosis and effective treatment, and primary techniques at preventing the occurrence of mental disorder by counteracting harmful influences leading to it.

1. Care of the Severely Ill

   A. In the hospital

      a. Open wards wherever possible

      b. Participation of patients and staff in group activity and patient government

      c. Control of disturbed behavior by psychotherapy; chemotherapy; social, occupational and work therapy; and rehabilitation programs

      d. Efforts to increase the contact between the patient in the hospital and the outside community—visiting is encouraged; home visits are frequent; volunteers are invited into the hospital

      e. The "unit system" by which large hospitals are divided into small subdivisions, each responsible for a geographic region of

the community.

B. In transitional facilities

a. The day hospital

b. The night hospital

c. Half-way houses where patients may live after leaving hospitals but before returning home

d. Ex-patient clubs

e. Family treatment

f. After-care services by family physicians, visiting nurses, psychiatric social workers, or other mental health workers

g. "Satellite" after-care clinics in the centers of population for remote hospitals.

2. Specific Preventive Measures

A. Home treatment services

B. Admission screening services provided by psychiatric hospitals

C. Preadmission services, frequently involving home visits (these frequently avert hospitalization)

D. Walk-in emergency treatment in the general hospital

E. Suicide prevention services

F. Psychiatric services in general hospitals

G. Outpatient treatment of adults and children

H. Counselling of college students

I. Consultation services to social agencies, courts, visiting nurses

J. Crisis intervention (assistance at special times as in entrance to college, after birth of premature babies, after death of close relatives).

3. General Preventive Measures

A. The achievement of increased freedom from poverty, improved living conditions and better education

B. Community education regarding certain principles of mental health

C. Communication between psychiatrists and allied groups—physicians, ministers, etc.

Mental Retardation and Community Psychiatry

It seems appropriate that the mentally retarded be included among the people served by community psychiatry. A number of studies have confirmed that a high percentage of children who are retarded in school are not essentially deficient in intellectual capacity, but are emotionally disturbed, culturally deprived, neglected, deserted, orphaned, brain damaged and sensorially handicapped in various combinations.[6] It has been estimated that about five million people in the United States are mentally retarded. These fall into three major categories: (1) The profoundly retarded or totally dependent, with IQs between 0 and 19, constitute about 0.1% of the total population and 3.5% of retardates or 180,000 persons; (2) the moderately or trainable retarded, with IQs of 20 through 49, represent 0.3% of the total population and 11% of retardates or 450,000 persons; and (3) the mildly or educable retarded, with IQs of 50 through 69 or 79, number about 4¼ million and constitute about 85% of the 5 million retarded persons.

The following is a list of suggested components of comprehensive services to the retarded:

1. Consultation services for obstetricians and pediatricians, who first discover the handicapped children, and who may be able to help the parents to keep the child at home when this is advisable.

2. Diagnostic, evaluative and counselling services for parents of retarded children.

3. Home visiting services to help a mother to keep moderately to severely retarded children at home during the early years of life—such mothers need special help with feeding, handling, toilet training, and disciplining of young children.

4. Nursery school-clinic programs to provide growth and training opportunities for children as well as an opportunity for adults to study the children in a natural environment.

5. Day care services for severely retarded persons who are excluded from special classes for the trainable or who are beyond the age limit for these classes—such centers would teach

self-help and would provide habit training and socialization.

6. Special education which would make it possible for retarded children to participate in as many regular classes as possible—the many mildly retarded children who are educable can "for the most part be made employable and will, after the spotlight of school programs is removed from them, blend anonymously into the general community."

7. Vocational training.

8. Recreational facilities for the more severely handicapped.

9. Institutional resources other than the usual permanent institutional care—educational institutions, half-way houses, and places for short-term emergency care during family illnesses or vacations.

Such programs as noted would help to compensate for inadequately staffed and overcrowded residential facilities.

The Situation in Maryland

For a long time it has been recognized in Maryland that emotional and behavioral disorders (including alcoholism) are among the important health problems of the State and that, for many patients, exclusive long-term treatment in large institutions deters rehabilitation. Despite a number of scattered efforts in various localities to improve mental health resources, diagnostic and treatment services at the local level have been inadequate or unavailable. The *Maryland State Comprehensive Plan for Community Mental Health Services* provides for the correction of such deficiencies. Based on a two-year study of State-wide needs and facilities—a study under the direction of Dr. Alice B. Tobler that involved many public health and mental health professionals, educators and knowledgeable citizens, this plan involves a shift from State-oriented care in large institutions to community- or local government-oriented facilities near a patient's home. It stresses the importance of services and organizational changes to keep patients in closer touch with their families and to avoid a complete or prolonged break with their families, jobs and community. It is wide in its scope, involving not only diagnosis and treatment of existing disorders, but far-reaching primary and secondary preventive measures, such as day nursery care, foster group care, vocational education, psychiatric court consultation, school psychiatric services, and services for the aged. It ranges from single component units of a coordinative program to be added to existing facilities



to completely new comprehensive mental health centers to be constructed in a few areas.

It provides for the support of this program by matching arrangements between the State and local communities. It also provides for the establishment of regional mental health directors who will work closely with county commissioners and the Baltimore city government, as well as with county and city health officers, the regional mental hospitals, and local advisory boards consisting of knowledgeable citizens and representatives of significant agencies. The idea is to preserve the function and authority of local health officers and to sustain the standards of the State Department of Mental Hygiene.

Since the comprehensive plan for mental health services is community based, it is geared to the geographical, historical and socio-cultural differences of the various areas of the State. To one familiar with Maryland and its regional characteristics and problems it is not surprising that the State has been divided into five major areas for planning purposes. As shown in the Figure, these areas have been designated as follows:

I. Metropolitan Baltimore
II. Maryland-National Capital area
III. Northwestern Maryland
IV. Eastern Shore
V. Southern Maryland.

To illustrate the differences discussed above, we shall briefly examine these areas. The inner city of the Baltimore Metropolitan area, with its high rates of mental and physical illness and every form of social and family disorganization, ranks first in the need for a community mental health center. Initial planning is under way for the first community mental health center, which will be located adjacent to the Baltimore professional campus of the University of Maryland. This center is a collaborative function of the State Department of Mental Hygiene and the Psychiatric Institute, University of Maryland School of Medicine, and will be operational by 1970. In anticipation of the development of Baltimore's first community mental health center, a pilot community mental health service program has been started in a limited area within the inner city.

Additional community mental health centers will be required in Baltimore City and are being planned in cooperation with The Johns Hopkins Hospital, Sinai Hospital of Baltimore, Inc., and the Baltimore City Hospitals. Three centers are planned for the densely populated sections of Baltimore County adjacent to Baltimore City. In Anne Arundel County, the Health Department and Crownsville State Hospital have already developed programs that chiefly serve children and adolescents and, therefore, further services for adults will be stressed. The program for Carroll County, which may also include Harford and Howard Counties, will center around Springfield State Hospital. The Maryland-National Capital Area (Prince George and Montgomery Counties) with its relatively affluent and educated population, has as high an incidence of social disorganization and mental illness as in Baltimore, but for different reasons than exist in Baltimore City. Here the presence of many families uprooted from their communities and functioning in tense competitive situations is believed to account for the great need for expanded mental health services, especially those for the adolescent age groups. A residential school for children with emotional problems is badly needed.

The western Maryland Counties (Allegany, Frederick, Garrett and Washington) need various social services for optimal development of mental health programs. Vocational and mechanical training courses for children and adults are predominant local needs. A comprehensive community mental health program will be started in each of these counties utilizing facilities already present (there are especially well developed ones in Frederick County), but no construction is planned for Garrett County because of its limited population and its geographic characteristics. It may be adequately served by programs in Cumberland. A regional health and mental health center is planned for Cumberland as part of the Appalachian Program.

The Eastern Shore area, consisting of nine small and sparsely populated counties, has a large proportion of families with incomes of less than $3,000 a year, and a high rate of children and elderly persons on welfare, all of which must be considered in planning. The hub of the mental health program there will be the Eastern Shore State Hospital. Two satellite centers are planned, one on the upper shore and one on the lower shore. The Southern Maryland area (Calvert,

Charles and St. Mary's Counties) is in need of a small State hospital, and there have been special requests for family counselling and vocational training.

This account merely touches on the high spots of the overall picture for Maryland; we may not have mentioned needs that the reader feels are great in his particular county. There has been no attempt to detail the various programs and clinic services already in operation as collaborative ventures of the State Department of Mental Hygiene, the State Department of Health and such major training institutions as The Johns Hopkins Hospital with its Community Psychiatry Training Program. It is recommended that the reader who is interested in further details study the *Maryland State Comprehensive Plan for Community Mental Health Services,* a copy of which may be obtained through the State Department of Mental Hygiene.

The Manpower Problem

In concluding, it would seem important to call attention to the greatest problem involved in establishing community mental health centers—the shortage of well trained and experienced psychiatric personnel. This shortage has been felt for several years in Maryland by almost all of the existing facilities. The new facilities will create an even wider deficit unless provisions are specifically included for the development of manpower resources. Since 1955 there has been a decrease in the number of institutionalized patients, but the trend of increased admission rates with shorter hospitalization periods makes tremendous demands upon institutional psychiatrists as well as those functioning in the community. These demands are reflected in the following statistics: In 1955 there were 558,000 patients institutionalized; by 1965 this had been reduced to 490,000. During the same period, the ambulatory outpatient treatment of psychiatric patients had risen better than two-fold from 379,000 to 862,000 patients. Further, there are only a small number of graduates per year who join the psychiatric manpower pool. A survey of the dimensions of the problem indicates that about 1,000 psychiatric residencies went unfilled in 1964-1965. Only 4,000 psychiatrists were in training during that period.

Another aspect of the manpower problem is related to apportionment, for a large number of psychiatrists remain in private practice, and many remain close to metropolitan areas where there are medical schools and major hospitals. Of the 15,000 psychiatrists in the United States, 80% are currently in private practice. This shortage means that those psychiatrists who are interested in community psychiatry must learn to serve as consultants to community organizations. They must receive training in the administration of mental health agencies, and they must learn to work in close collaboration with psychologists, social workers, public health nurses, and other professionals who have considerable competence in the mental health field, each within his own discipline. Above all, the psychiatrists and physicians of other specialties must learn to collaborate in the identification, prevention, diagnosis and treatment of mental illness. Manpower needs, then, include cooperative utilization of exisiting personnel, particularly family physicians and privately practicing psychiatrists, in novel and diverse ways. Vital to the successful operation of community mental health centers in Maryland are training opportunities for the variety of disciplinary groups active in the mental health field.

In the coming decade the State of Maryland has the opportunity to develop new patterns of service which are comprehensive and which ensure continuity of care. The involvement and active participation of the medical profession will broaden the base for community-centered mental health care and will lead to earlier case finding and treatment. Lastly, the medical profession will occupy a critical role in the primary prevention of mental illnesses because of its central position in providing early health care to the family.

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MEDICARE IN MARYLAND HOSPITALS

July 1966 and January 1967

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Prior to the advent of Medicare on July 1, 1966, there were many voices throughout the nation warning of the flood of Medicare patients that would inundate the hospitals as soon as the Medicare program started. Because of this concern, the Hospital Council of Maryland initiated a data-reporting system to determine the effect of the Medicare program during the one-month period of July 1966. The information included only the daily census in medical and surgical departments for patients under 65 years of age and those 65 years and over. Twenty-three hospitals in Maryland, representing more than half of all the medical-surgical beds, were included. The results of the study showed that the fear of a tremendous rush to hospitals was not realized.

Although there has been no great influx by the aged since the advent of Medicare, there is some indication nationally of a gradual increase in the use of hospitals by the aged. To test this supposition, the Hospital Council decided to re-survey Maryland hospitals. January 1967, six months after the original survey, was selected as the period appropriate for a follow-up study. The information gathered from hospitals was the same as before: each was asked to report, for each day of the month, the number of patients under 65 and the number of patients 65 years of age and over in the medical and surgical departments.

Table 1 presents an analysis of the responding hospitals broken down by geographic regions within the State. The regions include the following counties:

Baltimore: Anne Arundel, Baltimore, Carroll, Harford, Howard, and Baltimore City.

Western Maryland: Allegany, Frederick, Garrett, and Washington.

Southern Maryland: Calvert, Charles, and St. Mary's.

Montgomery-Pr. George's: Montgomery and Prince George's.

Eastern Shore: Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester.

Of the 46 general nonprofit hospitals in Maryland, 32 participated in the January survey. The number of beds in these 32 hospitals comprise 70% of all medical-surgical beds in the State. On a Statewide basis, this would appear to be an adequate sample. The only region which was underrepresented was the Montgomery-Prince George's region, with only 27% of the total medical-surgical beds accounted for.

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Table 1
ANALYSIS OF RESPONDING HOSPITALS BY REGIONS

	Number of Hospitals		Medical-Surgical Beds		Percent Medical-Surgical Beds in
	Total	Responding	Total	Responding	Responding Hospitals
State Total	46	32	7775	5462	70.3%
Balto. Metro. Area	20	14	4858	3552	73.1%
Region					
Baltimore (including Metro. Area)	23	16	5182	3750	72.4%
Western Maryland	6	5	788	723	91.8%
Montgomery-Prince George's	8	3	976	260	26.6%
Southern Maryland	3	2	220	120	54.5%
Eastern Shore	6	6	609	609	100.0%

Table 2
ANALYSIS OF MEDICAL-SURGICAL PATIENT-DAYS BY AGE OF PATIENT IN RESPONDING HOSPITALS, BY REGION, JANUARY 1967

	Total M-S Patient-days	Under 65	65 or Over	Percent 65 or Over
State Total	173,165	115,431	57,734	33.3%
Balto. Metro. Area	109,181	75,376	33,805	31.0%
Region				
Baltimore (including Metro. Area)	115,818	79,570	36,248	31.3%
Western Maryland	24,350	14,328	10,022	41.2%
Montgomery-Prince George's	9,240	6,316	2,924	31.6%
Southern Maryland	3,687	2,257	1,430	38.8%
Eastern Shore	20,070	12,960	7,110	35.4%

Table 2 summarizes the results of the survey, presenting the data by regions. In January, 33.3% of the medical-surgical patient-days involved patients of Medicare age. This is an increase of only one percentage point over the 32.3% in July, 1966. We therefore conclude that the population of Medicare age in Maryland has not significantly increased in Maryland hospitals. This supports the belief of many persons that medical care has been available to all persons needing it in Maryland regardless of their financial condition and that the Medicare program has merely changed, for some patients, the source of payment to the hospitals.

Table 3 shows the percentage of medical-surgical patient-days in each hospital involving patients of Medicare age. The data include the surveys made in July and in January. Where a hospital reported only in one of these periods, a dash has been placed in the appropriate column. More hospitals showed an increase in Medicare patients than showed a decrease. This was also true of the regions.

It is evident from these findings that, in Maryland hospitals, the dire forebodings of tremendous hospital increases among the aged have not materialized. This conclusion seems consistent with national data for July 1966 and November 1966 (the latest month available) as reported by *Hospitals, Journal of the American Hospital Association*. In July 1966 28.2% of patient-days were in the 65 and over category. This had increased to 30.2% in November, 1966. The conclusion also bears out the prediction of the Hospital Council in an earlier report (October 1965) that no more than 516 beds would be needed in Maryland by 1970 to care for the increase in patients resulting from the Medicare program.

(*continued*)

Table 3
PERCENTAGE OF MEDICAL-SURGICAL PATIENT-DAYS FOR PATIENTS OF MEDICARE AGE IN RESPONDING HOSPITALS, JULY 1966 AND JANUARY 1967, BY REGION

	July 1965	January 1967
Baltimore Metropolitan Area	28.4%	31.0%
Baltimore County General Hospital, Inc.	32.8%	30.7%
Bon Secours Hospital	25.2%	29.1%
Church Home and Hospital	21.4%	25.7%
Franklin Square Hospital	30.0%	30.4%
The Johns Hopkins Hospital	—	24.1%
Lutheran Hospital of Maryland	26.4%	27.5%
Maryland General Hospital	—	32.9%
Mercy Hospital, Inc.	30.6%	34.2%
North Arundel Hospital	20.0%	30.4%
North Charles General Hospital	—	24.2%
Provident Hospital	18.6%	23.0%
St. Agnes Hospital	27.7%	—
Sinai Hospital of Baltimore, Inc.	—	26.5%
The Union Memorial Hospital	43.0%	62.6%
University Hospital	22.4%	24.1%
Baltimore Region (including Metropolitan Area)	29.1%	31.3%
The Anne Arundel General Hospital	34.0%	36.8%
Carroll County General Hospital	47.1%	37.0%
Western Maryland Region	38.0%	41.2%
The Memorial Hospital (Cumberland)	36.5%	46.1%
Frederick Memorial Hospital, Inc.	51.1%	36.2%
Garrett County Memorial Hospital	61.7%	51.7%
Sacred Heart Hospital	39.5%	39.0%
Washington County Hospital	32.7%	37.8%
Montgomery-Prince George's Region	36.7%	31.6%
Eugene Leland Memorial Hospital	—	21.1%
Montgomery General Hospital, Inc.	39.0%	43.9%
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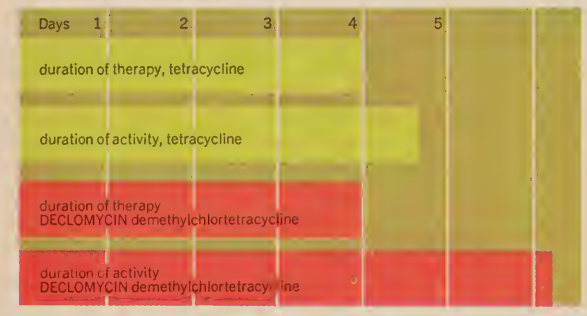
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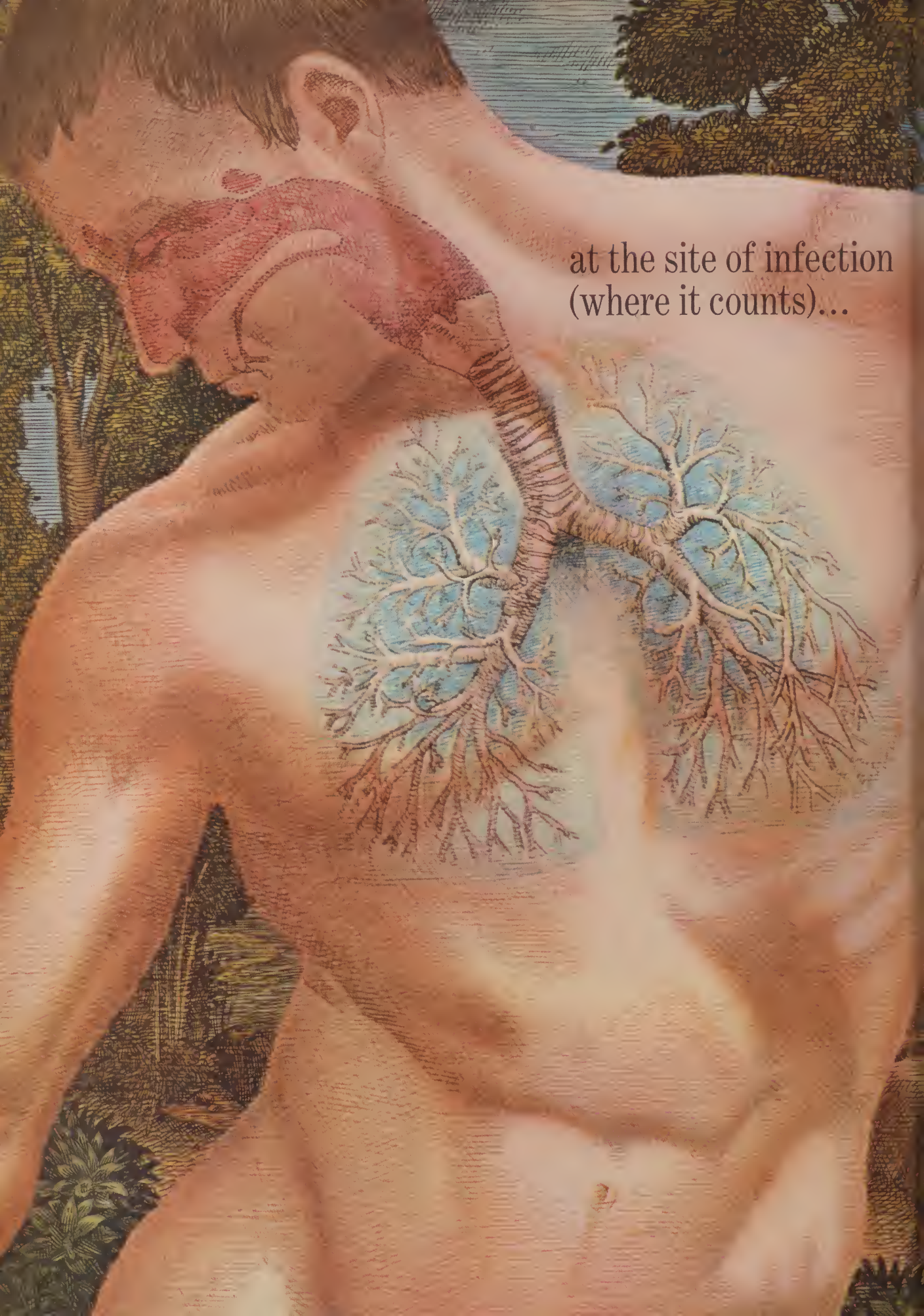
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In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

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(See next page for prescribing information.)

Ilosone®/ the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Side-Effects: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have appeared in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly if the drug is readministered to sensitive patients, usually within forty-eight hours. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appeared to be definitely related to use of the drug, laboratory findings were characterized by increased direct-reacting bilirubin, elevated alkaline phosphatase levels, negative or weakly positive cephalin flocculation and thymol turbidity tests, elevated serum glutamic oxalacetic transaminase levels, peripheral eosinophilia, and normal cholecystograms.

Individual idiosyncrasy seems evident since jaundice has not been reported in other patients taking prolonged courses of the medication. Patients with chronic infection have been given 1 to 2 Gm. of the drug daily for periods of two to six months, and patients with rheumatic fever have taken prophylactic doses of 0.5 Gm. daily for two years without difficulty. In one group of 144 patients who received the drug daily for two years, no jaundice was noted. It was of interest that members of six of the patients' families, who were not taking the drug, had episodes of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels were determined in a group of fifty-four adults and children who took 250 mg. of Ilosone daily for an average of sixteen months as rheumatic fever prophylaxis. The results were compared with those of a similar group of forty-four patients who received penicillin. There were no cases of jaundice in either group. Elevations of SGPT and serum alkaline phosphatase levels during the course of treatment was observed in one patient treated with Ilosone and in two patients treated with penicillin. Seven other patients in the group receiving Ilosone and four others in the penicillin group showed elevations in one of the tests at some time during administration of the drugs.

Very satisfactory therapeutic results, without toxicity, were reported in 102 pediatric patients who received short-term (ten day) courses of Ilosone in the treatment of streptococcus infections. Results of liver function tests in these patients were comparable to those in a similar control group who had received penicillin.

Gastro-intestinal disturbances not associated with hepatic effects are observed in a small proportion of individuals as a result of a local stimulating effect of the medication on the alimentary tract; however, the normal intestinal gram-negative bacterial flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with the use of erythromycin, there have been occasional reports of urticaria, skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orally.

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Ilosone Drops
Ilosone, 125, for Oral Suspension

For infants and for children under twenty-five pounds of body weight, the usual dosage is 5 mg. per pound every six hours; for children twenty-five to fifty pounds, 125 mg. every six hours. (Tablets Ilosone Chewable should be chewed or crushed and swallowed with water.)

For adults and for children over fifty pounds, the usual dosage of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythromycin therapy should be considered.

In the treatment of syphilis, the recommended total dosage is 20 to 30 Gm. given in divided doses for a period of ten to fifteen days. Close follow-up of the patient is necessary since erythromycin drugs have not had adequate evaluation in all stages of syphilis. Examinations of spinal fluid are recommended as part of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four days is recommended. In the treatment of gonorrhea, patients with a suspected lesion of syphilis should have a dark-field examination before receiving antibiotics, and monthly serologic tests should be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and 250 mg. (equivalent to base), in bottles of 24 and 100.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to base) in bottles of 50.

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 10-cc. size packages, with dropper calibrated at 25 and 50 mg.

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equivalent to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size packages.

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3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 19

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COMPONENT MEDICAL SOCIETIES

BALTIMORE CITY

All members of the board of directors of the Baltimore City Medical Society were present for the monthly meeting held on March 14 at 1211 Cathedral Street and conducted by **Harry J. Connolly, MD,** president of the Society.

William F. Pearce, MD, and **Leonard G. Hamberry, MD,** representing the Baltimore Civil Service Commission, brought to the attention of the board the differences in physicians' opinions often encountered in workmen's compensation cases. It was proposed by the board that a panel of physicians be formed for the purpose of arbitrating such differences. **Arthur Siwinski, MD,** suggested, and the board agreed, that such a step would require a legislative change; that the help of the Society's Legislative Committee and of the City Solicitor should therefore be enlisted to formulate the basis for a possible "bill"; and that their recommendations should be presented to the board of directors for final approval prior to the submission of such a bill for legislative action.

The aid of the BCMS was sought by **F. J. L. Blasingame, MD,** executive vice-president of the American Medical Association, in the form of a letter concerning "Health Manpower." Recognizing the need for an organized program, but aware of several such programs presently in operation, the board agreed that information should be gathered on what has already been established in order to determine how the Society can serve in the most efficient capacity.

Correspondence on the statewide measles immunization program between the Society and **Robert E. Farber, MD,** health commissioner of Baltimore City, was reviewed, and it was announced that a BCMS committee, of which **Donald W. Mintzer, MD,** is chairman, has already been formed to enlist the aid of city physicians in administering the vaccine. The Baltimore City Health Department will assist in the organization of the city campaign.

The need to update the file of physicians for referral purposes in handling public inquiries was discussed in detail. The board voted for continued use of a questionnaire for this project, but revised the questionnaire. . . . The recommendation to the Governor of **Herman Seidel, MD,** for reappointment to the Commission on the Problems of the Aging was unanimously approved. . . . The board directed that a letter be sent to *The Baltimore Sun* voicing disapproval of the distortion of facts in a recent article reporting the proceedings at the BCMS business meeting on March 3.

Arthur E. Cocco, MD
BCMS Representative to The Journal

WASHINGTON COUNTY

The Washington County Medical Society held its regular meeting at the Venice Restaurant on Thursday, March 16. The guest speaker was **C. Ronald Koons, MD,** a physician at The Johns Hopkins Hospital and instructor of medicine and radiology at The Johns Hopkins University School of Medicine. His topic was "Newer Aspects in Cancer Chemotherapy."

* * * * *

John C. Stauffer, MD, chairman of the Public Health and Legislation Committee, and members of his committee will meet with **Perry Stearns, MD,** acting county health officer, to formulate plans for the forthcoming Measles Immunization Sunday, May 21, 1967.

* * * * *

New members: **Rizalito Amarillo, MD,** general practice, Sharpsburg, Md.; **Percy Miller, MD,** chief of physical medicine and rehabilitation at Western Maryland State Hospital; **Andrew Mandell, MD,** general practice; and **Edwin Riley, MD,** staff physician at Western Maryland State Hospital, a transfer from Caroline County Medical Society.

John W. Clark, MD
Secretary

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A Day Care Center in an Institutional Setting—Rosewood State Hospital

AVRUM S. SHAVRICK, MEd
Principal, Rosewood State Hospital

A day care program for retarded children may serve the educable, the trainable, or the totally dependent (severely retarded), or it may attune its services to two or even three of these categories. Usually its purpose is to offer training not already available in the community through public or private facilities such as schools and nurseries. The rationale for a day care program is derived from two major goals—to serve the child and to assist the parents. The philosophy thus concurs with the thinking of Baumstein,[1] Jubenville[2] and other authorities. The child, through a program developed to meet his needs, is helped to reach his highest potential. His participation in planned activities assists him in becoming more self-sufficient and more effective as an individual. He has the opportunity to compete only with himself, rather than with his sisters, brothers, and even the neighbors.[3]

Concurrently, the family derives multiple benefits: Parents of retarded children shoulder a heavy responsibility; their children will remain dependent for a long period of time, perhaps all of their lives. Regrettably, they usually cannot look forward to the child's complete independence as can parents of normal children.[4] A day care center relieves the family of the 24-hour intensive supervision and care most of these retarded children require. As a result of having the child out of the home for several hours daily, the family is able, in some instances, to keep the young child at home, rather than seek residential placement in a facility, public or private, away from home. In addition, such a center often affords the parents their first real opportunity to assess their child objectively in relation to his retarded peers. Finally, family counselling, which is an integral part of a sound day care program, assists the parents in evaluating the child's potential and in reappraising the effect of the retardate on both parents and siblings.

Day care as a propitious service for retarded children is a relatively new concept in the program structure at Rosewood State Hospital, a residential institution for the mentally retarded located at Owings Mills, Md. A Day Care and Developmental Center was established in April 1961 as an adjunct to the Hospital's school for more than 400 youngsters who have IQs of 25 to 70 and who range in age from pre-school to teen years. Six young retarded children from the community, who could not be placed in existing local facilities, were enrolled in the pilot program. By February 1965, the number increased to its present enrollment of 12.

Eligibility criteria for the program are very flexible. Retarded children between 4½ and 10 years of age may enter. In general, the children reside within a 15-mile radius of the hospital. There are no tuition charges; however, the par-

ents are responsible for providing transportation, lunches, and some educational materials. No restriction is placed on degree of retardation, but the children must be at least partly ambulatory. Only those who are not admissible into other community facilities are accepted. The center operates during the regular school year from September through June, five days a week, from 9:30 AM to 2 PM. The ultimate aim of our program is to help each individual develop his full potential and be prepared socially, emotionally, and educationally to participate in and enjoy the programs in the community.

The Day Care Center offers a natural setting for parent education. Parent seminars are held once a month. These endeavor to guide the parents in a clear evaluation of their child's condition and in the setting of realistic goals both for their retarded child and for the family as a whole.[5, 6] Another facet of parent education is the dissemination of information on available community resources and facilities for both the retarded child and the family.

Parents are requested to observe and spend a day in the classroom at least twice a month. This observation has proven to be of invaluable service since it has enabled the parents to grasp more realistically the complexity of problems in the care and training of their child. It is the author's fervent belief that day care centers have come a long way in making programs meaningful and that the "baby sitting" connotation is gradually disappearing from the scene.

Volunteers play a vital role in the total program by providing meaningful recreational and educational activities, such as touring a farm[9] and taking trips into the community. Our volunteer program confirms the findings of several investigators[10] in demonstrating that there is often a marked improvement in the social skills and behavior of children drawn into activities by volunteers.

The Center also provides an opportunity for young pre-professional students to engage in field work. At the present time, a sophomore student from a local university is gaining useful experience in work with the retarded.

The children, their parents, and the staff of Rosewood's Day Care and Developmental Center have the advantage of utilizing other existing services of the hospital. Social workers, psychologists, and medical personnel are called upon as needed. This is truly a unique feature of the program and arises from the integration of the day program into a large residential facility.

An effectual staff is essential to a successful day care program. The teacher employed in a day center should be emotionally mature, have specialized training in early childhood education, have some experience in working with retarded children,[1] and be capable of communicating with parents and guiding them skillfully.

In a day care setting, it is highly desirable for the teacher to have freedom to organize the class according to the abilities and needs of the particular children in her group.[7] The teacher is the key factor in the educational process. In addition to her professional skills, she must be able to utilize the surrounding environment and adapt a wide variety of methods, tools, materials, and available space to meet the ever-changing needs of her pupils.[8]

The day care program is planned to include the pursuit of these sequential phases:

1. Observing the child's needs.
2. Planning a program which will satisfy these needs.
3. Putting the program into action.
4. Evaluating the progress of the child.

The classroom is bright and spacious. It is equipped with small tables and chairs and low open shelves for books and toys. Each child has his own marked locker. Adjoining this room is a sink with running water and a bathroom. Since the accent is on pre-school activities, the appurtenances are like those found in any other nursery school—dolls and accessories, crayons, clay, paint, books, blocks, balls, mobile toys, simple puzzles, and peg boards.

The children have the opportunity, in a very stimulating atmosphere, to work harmoniously together in a socializing situation and have the satisfaction of creating and constructing. All activities stress cooperation and turn-taking, and throughout the day every opportunity is taken to enhance growth in self-help and habit formation. All efforts are focused on helping the child to advance in self-care skills. Since progress is best assured in an environment where a child is enjoying happy experiences in a relaxed atmosphere,

equipment includes a record player, a piano, games, and rhythms. During each session the children receive speech and hearing training, and music, from specialists. Every activity is planned to introduce, stimulate, motivate, or provide practice in the skills which prepare for social acceptance and productive living in the school, home, and community. The program offers all of these facilities and skill-building activities and is soundly based on the thinking of Bateman,[11] Etz,[12] Kirk and Stevens,[13] Kirk and Johnson,[14] and Jubenville.[2]

There is, as there should be, heavy concentration on motor activities throughout each school day. The physical education program is geared to the development of large muscle activity to the fullest extent. The children have access to an outside play area which is large enough to provide general use of large muscles.[15] This area is enclosed so as to prevent youngsters from wandering away. Included in the enclosure is a paved area to enable the child to make full use of the mobile toys.

Many opportunities are afforded the youngsters in developing small muscle activity with the use of coordination materials, simple cutting with blunt scissors, and painting. Finger painting has been extremely popular with the children.

Once a skill has been mastered by the children, continued reenforcement, both in school and at home, is stressed. Too many times, such children are taken by the hand to the bathroom, for example, even after they have found independence in going alone. The parents, it is felt, are often guilty when it comes to instilling increasing independence in the severely retarded child. It is very difficult for parents to accept the fact that their retarded child has become semi-independent; they insist on doing everything for him.

At the end of each school day, the teacher meets with the parents for a few minutes to discuss briefly what they can do at home regarding reenforcement. Twice during the year, in September and in February, there is cooperative planning of the curriculum, and establishing of basic goals, by teacher, parents, principal, and psychologist.

Because defiant and inappropriate behavior in the classroom can be recognized, interpreted, and treated in a therapeutic manner,[16] in Rosewood's program the youngsters are reevaluated at fixed intervals by personnel of the psychology department.

Since the program's inception six years ago, 11 children have left the Center to attend other community facilities for retarded children. These facilities include public schools for trainable retardates, and private and residential schools.

In order to serve the needs of young retarded children and their parents, the Day Care and Developmental Center at Rosewood will continue to develop as an adjunct to community centers, for it is the community where total planning for the retardate should begin.

A day care facility can very often delay or even avoid residential placement for some children. It is generally believed that the institution can never supplant a mother's and a family's warmth and love for the child; consequently, the young child should remain in the home environment as long as possible, providing there is good home care and love for the child. The need for residential placement may be persistent and the demands great, but regardless of pressures used, home situations, if at all satisfactory, must be seen as the first preference for the young child.

At the present time, in our culture, the institution often carries negatory and very unpleasant connotations. This is one of the reasons why the residential placement of a child becomes a very disturbing, guilt-producing incident. A favorable experience in day placement in the same institution where the child may reside ultimately will go a long way toward reducing the emotional strain of such separation at a later date.

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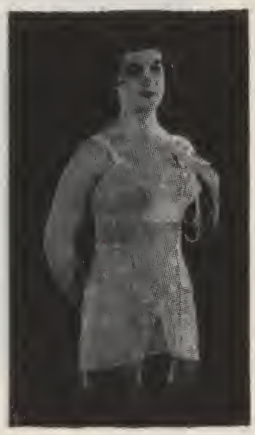
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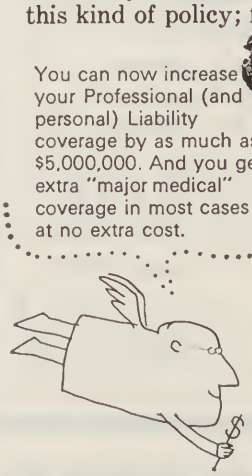
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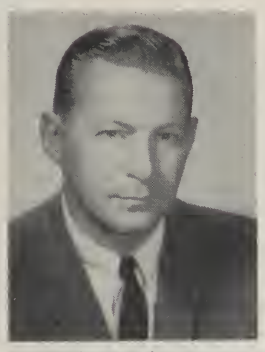
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IN BRIEF: One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth, blurring of vision, constipation, nausea, vomiting, bloating and dizziness may occur but are usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy — withhold in glaucoma. Contraindicated in patients sensitive to phenobarbital and/or Cantil (mepenzolate bromide); in toxic megacolon, obstruction of G. I. or G. U. tract.

SUPPLIED: CANTIL (mepenzolate bromide) — 25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL — containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

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*…ch, I. W., and Lowell, F. C.: New England …M. 261:478, 1959.

Contraindications: Patients hypersensitive to antihistamines. Not recommended for use during pregnancy.

Precautions: Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.

Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability, or excitement may be encountered.

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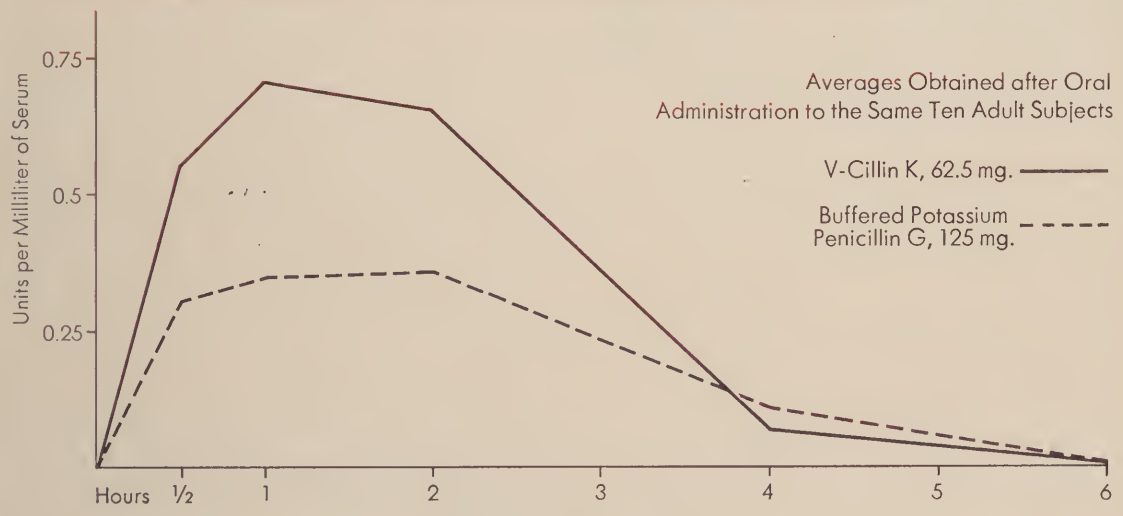
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Antibiotic	Staph. Aureus (Penicillin-Sensitive) MIC (mcg./ml.) Median	Range	Streptococcus, Group A MIC (mcg./ml.) Median	Range	Diplococcus Pneumoniae MIC (mcg./ml.) Median	Range
Penicillin V	0.02	0.02-0.04	0.02	0.003-0.4	0.01	0.005-0.2
Penicillin G	0.02	0.005-1.6	0.005	0.002-0.2	0.02	0.01-0.1
Methicillin	1.6	0.4-6.3	0.2	0.1-0.4	0.2	0.1-1.6
Oxacillin	0.4	0.1-3.1	0.04	0.02-0.4	0.1	0.04-0.8
Cloxacillin	0.2	0.2-0.8	0.1	0.1-0.8	—	—
Nafcillin	0.4	0.2-0.8	0.04	0.02-0.1	0.02	0.02-0.2
Ampicillin	0.2	0.1-0.8	0.02	0.01-0.04	0.02	0.01-0.04

Adapted from Klein, J. O., and Finland, M.: New England J. Med., 269 1019, 1963.

with high blood levels, even in the presence of food



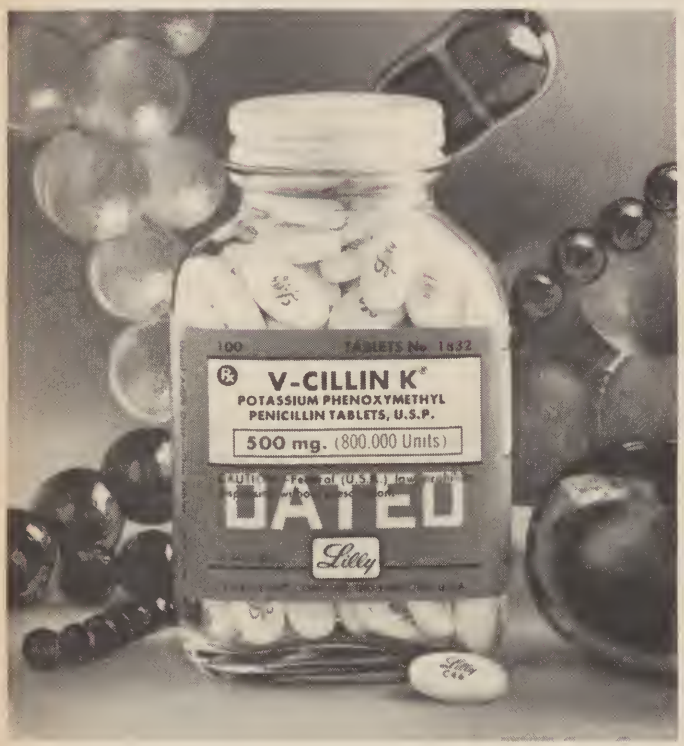
Adapted from Griffith, R. S., and Black, H. R.: Current Ther. Res., 6:253, 1964.

V-Cillin K® Lilly 700157

Potassium Phenoxymethyl Penicillin

(See next page for prescribing information.)

New 500 mg. tablets...a more convenient way to give high doses



Description: V-Cillin K is the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly). This chemically improved form combines acid stability with immediate solubility and rapid absorption. Higher serum levels are obtained more rapidly with this penicillin than with equal oral doses of penicillin G. The higher serum levels and acid stability of V-Cillin K make it a more dependable penicillin for oral use.

V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

Indications: V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy. Reactions occur more frequently in individuals with bronchial asthma or other allergies or in those who have previously demonstrated sensitivity to penicillin. If hypersensitivity reactions occur, the drug should be discontinued.

Adverse Reactions: Although serious allergic reactions are more less common with administration of oral penicillin than with intramuscular forms, skin rash, symptoms resembling those of serum sickness other manifestations of penicillin allergy may occur. When penicillin administered, measures for treating anaphylaxis should be readily available. Those include epinephrine, oxygen, and pressor drugs relief of immediate allergic manifestations as well as antihistamines and corticosteroids for delayed effects.

The use of antimicrobial agents may be associated with the overgrowth of antibiotic-resistant organisms; in such a case, antibiotic administration should be stopped and appropriate measures taken.

Administration and Dosage: For Tablets V-Cillin K and for V-Cillin K, Pediatric, the usual dosage ranges from 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, the daily dosage may be 50 mg. per Kg. of body weight divided into three doses.

Beta-hemolytic streptococcus infections without associated bacteremia may be treated with 200,000 to 400,000 units three times a day. Therapy should be continued for a minimum of ten days to prevent development of rheumatic fever and/or other serious complications. The dosage for routine streptococcus prophylaxis in patients with a history of rheumatic fever or congenital heart disease may be 200,000 units once or twice daily. When such patients undergo tonsillectomy, tooth extraction, or other minor surgery, the prophylactic dose should be 500,000 units every six hours given two days prior to surgery and for two days postoperatively. If oral medication is not feasible on the day of surgery, parenteral therapy should be considered. Mild to moderately severe pneumococcus pneumonia has been treated effectively with 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be given every six to eight hours in conjunction with indicated surgical procedures.

For gonorrhea in males, 500 mg. (800,000 units) every six hours three doses may be employed; in females, 500 mg. every four hours six doses are recommended. Patients with a suspected lesion of syphilis should have a dark-field examination before receiving penicillin and monthly serologic tests for a minimum of three months.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units) bottles of 50 and 100; 250 mg. (400,000 units), and 500 mg. (800,000 units) in bottles of 24 and 100.

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 units) 5 cc. of solution, in 40, 80, and 150-cc.-size packages.

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

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REHABILITATION Notes

REHABILITATION SECTION
BALTIMORE CITY MEDICAL SOCIETY,

DOUGLAS G. CARROLL M.D.
EDITOR

Why Do You Prescribe Exercise, Doctor?

CLARA J. FLEISCHER, MD
Assistant Professor, Physical Medicine and Rehabilitation
University of Maryland School of Medicine

Frequently the doctor refers a patient to a physical therapist for "exercise." Does he have a clear concept of why he ordered this form of therapy? Is he familiar with different forms of exercise and what they are supposed to accomplish?

Therapeutic exercise is a scientific application of bodily movements in the treatment of disease or of malfunction of the musculoskeletal system. The prescription for therapeutic exercise is directed toward:

1. Correction of impairment of joint range of motion.[1]
2. Improvement of muscle function, strength, and endurance.[1]
3. Improvement of coordination.[1]
4. Maintenance of a state of wellbeing.[2]

The prescription will vary with the purpose for which it is prescribed and it is directly dependent upon the condition of the patient. An adequate medical evaluation is therefore essential. The prescription must include objective goals *and* precautions.

1. Correction of impairment of joint range of motion

Limitation of range of motion is produced by:

A. Immobilization
B. Edema
C. Trauma
D. Impaired circulation

To improve or restore range of motion of joints, we employ (1) passive exercise, (2) active assistive exercise, (3) active exercise:

Passive exercise (or relaxed movement): The operator or mechanical device moves a portion of the patient's body while the patient remains relaxed. This is primarily of value in the treatment or prevention of stiff joints. The procedure is also useful in the presence of contractures, scar tissues, and muscle paresis due to a central or a peripheral nerve lesion which makes voluntary movement impossible. It will *not* hypertrophy the muscle fibers or improve peripheral circulation.

Active assistive exercise: This involves the initiation of the movement by the patient with the assistance of the therapist or mechanical devices, such as pulleys, to encourage full range of motion. This type of exercise will produce a gradual increase in joint and muscle efficiency.

Active (or free) exercise: The patient performs the movement himself against the resistance of gravity. This form of exercise not only improves the range of motion, but it also improves the muscular function, although not

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necessarily the strength.

2. Improvement of muscle function, strength, and endurance

The impairment of muscle function may be due to:

A. Disuse atrophy—inactivity or immobilization produces atrophy or reduction in size of muscle fibers rendering them functionally inefficient. Progressive resistive exercises will produce hypertrophy in muscles atrophied by disuse.

B. Paralytic atrophy—disease of, or damage to, part or all of the motor unit will produce a reduction in the size and number of muscle fibers. Progressive resistive exercises will hypertrophy only those fibers in which the motor unit is intact or recovered.

C. Misuse of muscles—fatigue, which by definition is a reduction in ability of the muscles to respond to a stimulus, is caused by depletion of chemical reserves and accumulation of waste products of muscle metabolism. It is a transitory state capable of recovery after rest. In treating failing muscular function, three major qualities of muscular performance should be developed: (1) power or strength, (2) endurance and (3) speed.

Power or strength is produced by resistive exercise: Here the patient uses his muscles against an opposing force supplied either manually by the therapist, or mechanically by weights or springs. It is generally accepted that active contraction of muscles causes marked increases in local blood flow in response to elevated metabolic needs of the tissues. Repeated active exercise, gradually increasing in intensity, will help to prevent atrophy and may contribute to hypertrophy of working muscles. It also counteracts the state of debilitation which inevitably follows prolonged bed rest. As a result, the negative nitrogen balance and the loss of vasomotor control over the blood vessels in the lower extremities is minimized. The improved circulation to bone and joint structures will have beneficial action in prevention of osteoporosis, contractures, and ankylosis. To increase muscle power or strength, one must gradually increase the work load of the muscle by providing resistance against the range of motion. Dr. DeLorme has shown that increased strength does not necessarily mean increased endurance.[3]

Endurance is improved only by repetition. Exercises performed with a low number of repetitions and increased work load will improve power *and* endurance.

Speed is gained by gradually increasing the number of repetitions per unit of time.

3. Improvement of coordination

Coordination is a combination of activities of a number of muscles in a smooth pattern. Ordinarily these movements are automatic. Control of coordinated activities is monitored primarily through the feed-back of sensory stimuli transmitted through proprioceptive pathways. Occasionally they are monitored by visual and tactile stimuli. Development of coordination depends upon the repetition of precisely performed patterns. The activity must be slow and precise. These activities are done many times and the speed of performance is gradually increased. All skilled muscular activities are developed in this manner.

4. Maintenance of a state of wellbeing

A so-called "normal" individual, or one who has a disease of an organ but no involvement of the neuro-musculoskeletal system, may require exercise for "physical fitness." The previously discussed factors of speed, strength, endurance, and coordination[2] are requirements of physical fitness and their degree is related to an organically sound body, ability to perform moderate and strenuous work, and ability to perform specific skills. In developing physical fitness, one must take into consideration the physiologic reactions of the body at different ages, the daily work performed by the individual, and the best exercise for the age of that person.

Only the basic concepts of exercise have been outlined here. It is to be hoped that future articles will discuss exercise in specific diseases, such as arthritis, pulmonary disease, heart and vascular disease, various orthopedic disorders, postural exercise, and exercise for specific neuromuscular disorders.

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3. DeLorme, T. L.: Restoration of Muscle Power with Heavy Resistance Exercise, *J of Bone and Joint Surg* 27:645, 1945.

Geigy

Tandearil®
oxyphenbutazone

helps osteoarthritic joints move again



3 out of 4 osteoarthritics completely or markedly improved

Sperling, I.L.: 3 Years' Experience with Oxyphenbutazone in the Treatment of Rheumatic Disorders, Applied Therapeutics 6:117, 1964.	76.9% of 407 patients
Watts, T.W., Jr.: Treatment of Rheumatoid Disorders with Oxyphenbutazone, Clin. Med. 73:65, 1966.	84.6% of 39 patients

Please see adjoining page for brief prescribing summary

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Therapeutic Effects: Tandearil is a nonhormonal compound which may rapidly resolve inflammation and help restore normal joint function. Its action does not affect pituitary-adrenal function or impair immune responses. Its value in osteoarthritis is especially noteworthy because this disorder responds inconsistently to steroids and is often resistant to salicylates. Further, indomethacin is limited only to osteoarthritis of the hip, whereas oxyphenbutazone is effective in all forms of the disease.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

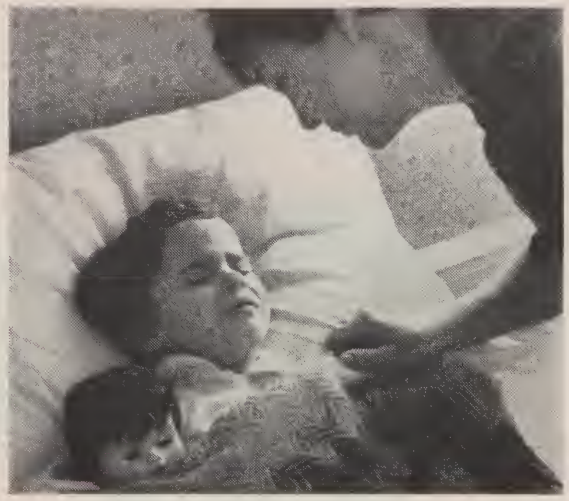
Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: The initial daily dosage in adults is 300-600 mg. in divided daily doses. When improvement occurs, dosage should be decreased to the minimum effective level; this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

For complete details, please refer to full prescribing information. 6562-VI(B)R

Availability: Tablets of 100 mg.

Geigy
Geigy Pharmaceuticals
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One by one the family's downed Because the G.I. bug's around

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric*
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and protects intestinal mucosa

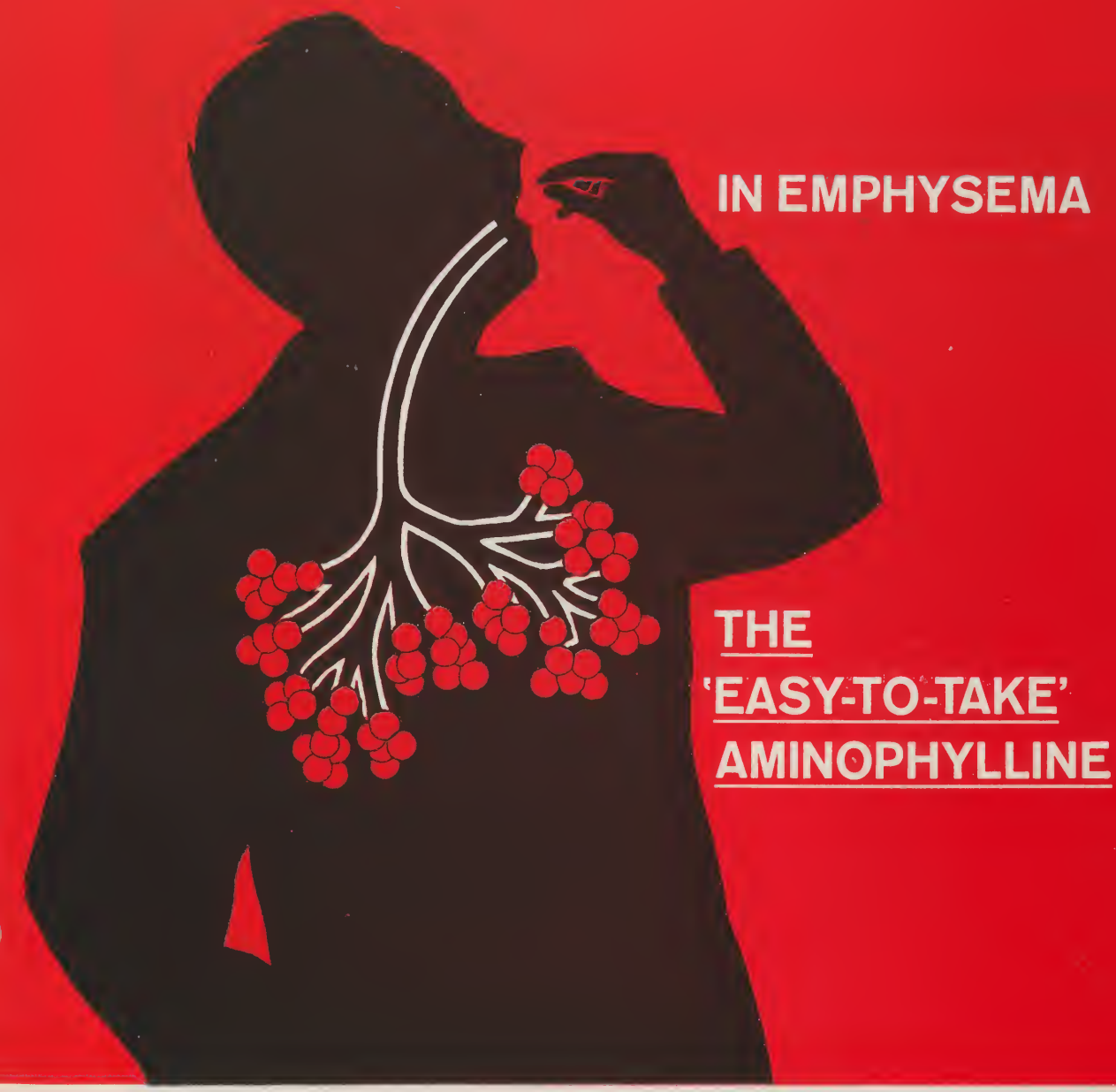
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*Paregoric (equivalent) ..... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
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Usual Adult Dose: One or two tablespoonfuls three times daily.
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Precautions: Use with caution in patients with poor renal function as a decreased rate of excretion may lead to accumulation and untoward reactions. Gastric irritation may occasionally be observed in certain patients sensitive to oral aminophylline.

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STATE OF MARYLAND

Department of Mental Hygiene

Isadore Tuerk, MD, Commissioner

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Maryland's Privately Operated Psychiatric Hospitals*

Fifteen percent of all psychiatric inpatient admissions in Maryland last year were to the eight privately operated hospitals although these provide less than nine percent of available beds. A slightly smaller number were reported to the Psychiatric Case Register as having been admitted to the VA Hospital at Perry Point and to other units not affiliated with the Department. The remaining 70% were to the six State psychiatric hospitals operated by the Department of Mental Hygiene. Patient movement data for the year ending June 30, 1966 are summarized in the following table.

TYPE OF FACILITY	Resident Patient Population 7-1-65	Admissions During Year**	Discharges During Year**	Deaths During Year	Resident Patient Population 6-30-66
DMH Operated	8,293	9,675	8,706	1,029	8,178
Privately Operated	929	2,233	2,261	24	877
Other Inpatient***	1,373	2,102	1,758	90	1,627
Total	10,595	14,010	12,725	1,143	10,682

Proportionally, Maryland has always had a substantial segment of its psychiatric patient population treated in privately operated facilities. One of these, the Seton Institute, has been in continuous existence for more than one hundred years. It is mentioned by Albert Deutsch in his book "The Mentally Ill In America" as one of the oldest psychiatric hospitals in the United States. This history of service is exceeded in Maryland only by the Spring Grove State Hospital. The number of these private hospitals has declined in recent years due to the closing of Cedarcroft, Laurel and other facilities because of personnel shortages and other related problems. There have been no replacements although a number of existing hospitals have increased their bed capacity. Several have also developed outpatient programs.

Traditionally, the relatively high cost of hospital care in these private facilities has produced a patient population with an excess of individuals with the following characteristics: white, female, in the middle years of life (25-54), middle and upper middle class, admitted for the short term treatment of acute nonpsychotic disturbances. In more recent years the inclusion of psychiatric care in health insurance programs has greatly broadened this population pool. At the same time, tranquilizing drugs and the development of new treatment concepts and services have produced

*Brook Lane Center, Chestnut Lodge, Gundry Sanitarium, Riggs Cottage, Seton Institute, Sheppard & Enoch Pratt Hospital, Taylor Manor and Washington Sanitarium.

**Does not include placements on or returns from long term leave.

***One county operated, one VA, and three psychiatric units of general hospitals.

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major changes in patterns of hospitalization, retention and release of state hospital patients.

Thus, individuals entering public or private psychiatric hospitals are now more comparable than they have been in past years. The quality and type of services received during hospitalization is now also more similar. Continuation of this trend should produce greater coordination of programs. It should also be an important factor in providing needed psychiatric services to all segments of the population.



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References: 1. Based on 1966 data from independent physicians' market survey organization. 2. Scal, J. C.: Eye Ear Nose & Throat Month. **38**:738 (Sept.) 1959.

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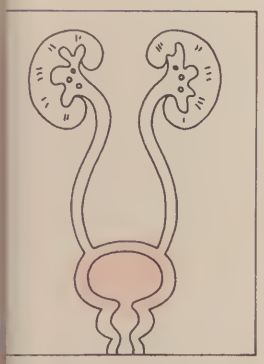
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1. Peters, J. H.: *J. Urol.*, *87*:747, 1962. 2. Draper, J. W., *et al.*: *South. M. J.*, *57*:920, 1964. 3. Stewart, B. L.: *J. Urol.*, *87*:491, 1962. 4. Hagstrom, R. S.: *Rocky Mountain M. J.*, *59*:(2), 37, 1962. 5. Arnold, J. H.: *Clin. Med.*, *71*:552, 1964. 6. Nelson, C. G.: *Colorado GP*, *3*:(3), 2, 1961.

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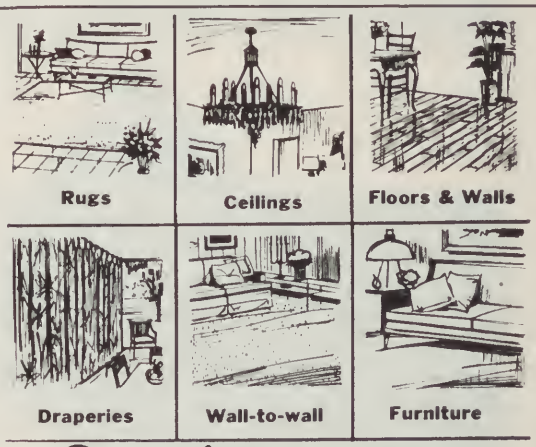
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Alcoholism SECTION

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

The Alcoholic and the Physician

RICHARD S. COOK, MD
Chief, Division of Alcoholism
Illinois Department of Mental Health

While there is much discussion about the diagnosis of alcoholism, a physician usually can determine from the history, as given by the patient or by the patient's family, if he is dealing with alcoholism. Typically, there is an account of excessive drinking, unpredictable use of alcoholic beverages, with consequences which disrupt the patient's family life or his employment or which indicate some impairment of health as a result of his drinking. The drinking has progressed to being recurrently troublesome. Friends and relatives have evolved a sort of common-sense effort, urging, pleading, threatening, and have gone along with many new starts before any professional consultation is sought.

It does happen that a family or patient consults a doctor because the situation regarding drinking is beginning to get out of hand, and there may be a question about calling the condition alcoholism or heavy social drinking.

It is not my purpose to review the various medical complications of alcoholism except to comment that in such conditions as severely agitated states with hallucinations, coma, or convulsions, one must think of alcoholism in the differential diagnosis. Conversely, when a known alcoholic is lying on the floor or street unconscious, it is not safe to assume that he is merely in an alcoholic stupor. He may be unconscious because of severe head injury or other pathological state.

Alcoholism is the fourth ranking public health problem in the United States, there being an estimated five and a half to six million alcoholics. For example, in Illinois there are probably around 375,000, at least half of whom are in Cook county. They tend to be, of course, larger in numbers around cities. Of this group, only about 3% are found on Skid Row, so if there is an assumption that the problem is mainly among the unemployed derelicts, it is far from the truth.

It is thought that about 3% of all employed people are alcoholic. The ratio of men to women alcoholics is about four to one, but some authorities have claimed that the ratio would be closer to two to one or one to one, if all the women alcoholics could be counted. They are not counted because they don't get into public places or hospitals, where the cases are reported.

In this presentation an attempt will be made to indicate some of the relations between the physician and the alcoholic patient as viewed by a psychiatrist with special interest in alcoholism. It is not intended that this be a comprehensive review or survey, nor is it a report of original research. The scope of the topic will be more or

Presented at the 78th Annual Meeting of the American Association of Railway Surgeons, Chicago, Ill. Reprinted from *Industrial Medicine and Surgery*, Oct 1966, with the permission of the editor and the author.

less limited to some aspects of the author's experience and some recent trends and developments which may prove stimulating and helpful in dealings with alcoholism, either in the railroad industry or in the medical field.

Nature of Alcoholism

There are different conceptions concerning the nature of alcoholism and its etiology. In the author's opinion the most useful view is the understanding of alcoholism as primarily a disorder of behavior, an emotional illness or a mental illness. This condition is recognized as mental illness by its inclusion in the "Diagnostic and Statistical Manual of Mental Disorders," published by the American Psychiatric Association.

In considering the nature of alcoholism, we must account for (1) the onset of alcoholism after puberty or early adolescence; (2) the fact that drinking is a rather complex voluntary act which is carried to an extreme by repetition; (3) the obvious finding that there is no single type of alcoholic personality, and that there is a great individual variation in the personality make-up among people who drink excessively; (4) the observation that in addition to the symptom of excessive, urgent drinking, these people nearly always have more or less severe difficulties in getting along with their families or others, show some other symptoms of emotional disorder, such as depression, severe anxiety, feelings of inferiority, phobias, or some recognizable psychosomatic condition, including peptic ulcer, hypertension, functional bowel distress, and so forth; and (5) the experience reported over and over again by alcoholics that abstaining from drinking does not, in itself, provide the alcoholic with personal adjustment, serenity, or satisfaction from living.

This is an incomplete list of the clinical features which must be accounted for by our understanding of alcoholism, but it is enough to remind us that we are discussing a complex condition, one which is not really encompassed by aiming at sobriety or abstention on the part of each alcoholic. In other words, there is much more to alcoholism than the drinking itself.

For purposes of this essay, alcoholism is conceived of as a condition in which the drinking is the symptom of an underlying emotional disorder, which is the primary difficulty and which precedes the actual appearance of excessive drinking. It is also assumed that if an alcoholic patient had been seen clinically by a psychiatrist before he became a compulsive drinker, he would have been found to have a clinically recognizable emotional disorder which, at that time, could have been defined as a psychoneurosis or, less often, a psychosis.

The emotional disorder varies from case to case and may be related to different stages of emotional development. The alcoholism represents the way in which the particular subject reaches out in an effort to cope with anxieties, depressions, feelings of inferiority, or other painful affects.

Now, what about a biological factor in the causation of alcoholism? There may be such a biological factor in what leads to this condition, but, at the present time, the evidence for this is inconclusive, and this conception does not help in dealing with the problem and treatment. Whether or not there is an organic explanation for some aspects of alcoholism, there is a great need to understand the psychology of the alcoholic, in a valid attempt to treat him.

Treatment of the Alcoholic

The treatment of the alcoholic represents certain problems to any professional, be he a general practitioner, an internist, a psychiatrist, or a member of an agency staffed by social workers and psychologists. In the first place, more often than not, the alcoholic does not present himself for treatment, but, rather, contact on behalf of the alcoholic is made with the physician through an intermediary, the wife or other relative of an alcoholic, a minister, employer, attorney, or a judge. In a certain number of cases, the alcoholic will call the doctor himself. His call may be associated with the realization that he is in trouble regarding the drinking because of the onset of some complication of drinking or due to his responding to pressure from some outside person.

When the doctor meets the alcoholic patient, he often finds that the alcoholic is not interested in any treatment or that he avoids acknowledging that he drinks pathologically by denying it, by minimizing it, or by simply explaining it away.

The alcoholism tends to be exasperatingly recurrent. The physician often runs the gamut of his ingenuity and armamentarium, and still the drinking recurs.

In the course of his dealings with the doctor,

the alcoholic often demands much time because of drinking episodes and their complications, which lead to many visits or telephone calls by the patient and by the patient's relatives. In addition to this requirement of excessive time, the patient often proves to be financially unreliable. Understandably, this leads the doctor to hesitate to treat many of these people.

Many physicians probably deal effectively with the alcoholic and succeed in ushering him into examination and treatment. They then help him to drink less or to abstain. For those who do not deal successfully with the alcoholic and would like to, a few suggestions are made: The initial contact with the patient is very important. It may be that the first meeting will be by telephone and not in person. The doctor's relationship with his alcoholic patient begins at the moment of his earliest verbal exchange with the patient or, for that matter, with the patient's relatives. Even the receptionist may be a factor in whether the alcoholic accepts the notion of being treated or feels that he has met with one more rebuff.

In preparation for this initial contact the attitude and orientation of the physician count a great deal. One cannot be helpful to the alcoholic patient unless he can accept him without moral overtones and with medical objectivity and interest. This is not a simple hurdle to surmount. It may turn out that some of us cannot free ourselves from bias. The alcoholic is very sensitive to rejection in any form and yet does not always respond to the sincere interest and intent on the part of the doctor. It is almost as if the alcoholic wants to reserve the right to reject the helper, but he wants the physician to be always understanding and infinitely patient with him.

This is not an easy slot to fill. However, it is a prerequisite for the helping person, the doctor, to approximate a disposition of continued acceptance, unending patience, and therapeutic interest if the treatment is to be effective.

At the start of the relationship it is vital to let the patient know that you are his ally and not merely a tool through which the family expects to manipulate the patient. This alliance must not be interpreted to mean that the doctor needs to be hamstrung by his own promise, implied or expressed, in acting in the best interests of the patient. On the other hand, it is well to avoid any move that would give the patient the impression that he is being taken advantage of. This means, of course, if some crisis comes up and the doctor has to take some kind of action without, possibly, consulting the patient.

In the course of the treatment relationship there may be more than one occasion when the doctor makes delicate decisions during some crisis, which may jeopardize the future treatment. Usually the doctor can find a way of preserving the relationship with the patient even though he has had to act forcibly towards him and effect a temporary alliance with a relative or community agency.

Here, too, the doctor must try always to act in the best interest of the patient, even though the latter may not agree at the time with the step to be taken. Later, one can approach the patient with the notion that if he had not put himself into such a helpless position, the physician would not have had to act in a seemingly high-handed way on his behalf.

Psycho-pathology of Alcoholism

In regard to alcoholism, as with any other disease, it is well to keep in mind the pathology, and in this case the psycho-pathology, in deciding what treatment to use. The most salient features of the psycho-pathology include the following:

a. The drinking is a symptom which represents the way in which the patient is trying, albeit ineffectively, to handle some painful feeling. Incidentally, the patient may not be aware that his drinking serves this purpose.

b. Before the drinking became excessive, the patient had severe emotional problems which were neurotic or, less often, even psychotic in nature, and which produced the painful affect and other aspects of his irrational behavior.

c. Concurrent with the uncontrolled drinking, the patient developed certain personality modifications to enable him to cling to drinking despite his own common sense and the influence of others around him. These modifications or mechanisms include denial, rationalization, projection, pathological lying, deception, and other psychological devices to enable holding on to the drinking.

d. The condition of alcoholism is recurrent and chronic. It is well to note this: in planning on the part of one of the committees of the American Psychiatric Association, it, in effect, planned for lifelong care for the alcoholic. This may seem to be a little pessimistic, but it shows that we are

beginning to accept the idea that we are not dealing with an always-curable illness, at least not at this particular date.

Treatment

Once the patient has accepted the idea of treatment, the doctor has various means at his disposal for dealing with these patients. This amounts to four main categories. One is emotional support; another is medical management; the third is referral; and the fourth is collaborative management. These means of helping the alcoholic need not exist in pure culture and may be combined in any way that experience, intuition, and common sense dictate.

These four main features, (a) through (d), will serve as a useful guide in dealing with alcoholism, although this is only a minimal diagram of an alcoholic patient, and other characteristics could have been selected.

The first category mentioned, of help, is emotional support. Emotional support for the alcoholic patient means that the physician communicates something to the patient which assists the patient in feeling more comfortable in facing external tasks and in dealing with feelings and urges, including the impulse to drink. But this does not mean coddling the patient, making his decisions for him, or trying to make up to the patient for the deprivations of his childhood. It does require an interest on the part of the doctor which is tempered by the acceptance of the nature of the alcoholic's problems and his emotional make-up. The attitude of the helping person must be as free as possible from contempt, preconceived judgments, and, certainly, condemnation. Sometimes support means saying things to the patient which enable him to exercise his own judgment more effectively or to accept responsibility more readily. In some instances, merely listening to the patient, showing concern, along with reasonable encouragement, enables significant clinical improvement.

The capacity to render effective support to an alcoholic patient does not necessarily require detailed knowledge about the psychology of alcoholism, but some accurate information about it may go a long way to enable each physician to make the best use of what time he has to treat this type of patient.

The medical support would involve treating the emotional symptoms and medical symptoms. Here the substitution of some other drug for alcohol is one method. The danger, of course, is to exchange one addiction for another. This is very real. In order to avoid this, try to give this type of medication only to patients you are actively following and seeing fairly regularly, and try, even at some inconvenience, to use non-refillable prescriptions so that the patient and physician both are reminded of how much and how frequently he is using his medication.

Insomnia and Depression

Under medical support one would be dealing with insomnia and depression. Here, too, the caution about giving prescriptions and not paying attention to how much and how frequently they are being refilled is very important. Needless to say, there are a number of suicides and accidental deaths among alcoholics, and when one deals with both the outpatient clinic level and the state hospital level, one sees how frequently this happens.

The drinking itself can be dealt with sometimes using antabuse which sensitizes the patient to taking alcohol, so that he must wait 24 to 48 hours before he takes a drink and after he stops taking medication. The author prefers to use antabuse in conjunction with other therapeutic technique.

Sometimes a physician with some interest in the subject can maintain a patient on antabuse, see him fairly regularly for brief periods of time, and do very well in controlling the drinking.

The Referral Method

Referral is definitely a method of dealing with the alcoholic, and here is an opportunity for a physician to reevaluate what he is doing in the community and in his own practice with alcoholism. The problem of alcoholism will never be solved by the medical profession alone; that is, physicians including psychiatrists. Each of us should do what he can in his own private practice to not simply disregard the alcoholic but to try to help him, try to develop some talent for dealing with him.

The problem of alcoholism goes well beyond the medical profession, and we need to tap municipal, state and federal sources in order to encompass the problem.

In each state, or states, there are alcoholism

agencies which might be of great help, and to which patients can be referred.

Referral doesn't mean that the doctor necessarily loses a patient. The state agency would rather have a patient who has been in a state hospital or a patient who has come to the clinic go back to his family doctor for his medication or for any other medical care that he needs.

Patients can also be referred to appropriate sanitaria. More and more psychiatric wards of general hospitals are taking alcoholic patients.

Alcoholics Anonymous

There is no question about the importance of Alcoholics Anonymous. It has proved its worth to many alcoholics. On the other hand, Alcoholics Anonymous is not a professional organization in the ordinary sense. It has a definite ceiling on how much it can modify its techniques and grow. On the other hand, professional scientific methods are theoretically without any such limit, and certainly need to be fostered and developed.

Alcoholics Anonymous is used in state work with alcoholic patients, as well as in private practice. It is deplorable that the medical profession tends to dump the problem of alcoholism on Alcoholics Anonymous. This is objectionable because we have a responsibility that is different from theirs. They can do some things that we cannot do; on the other hand, in the long run, we can do some things that they cannot do.

There are many alcoholics who will not have anything to do with Alcoholics Anonymous. This is not a criticism of the patient nor of the organization, but it simply indicates that no one method is best for all alcoholics, and there is plenty of room for new methods and new ideas in dealing with this illness.

Social Workers and Psychologists

With respect to the idea of collaborative management, if a psychologist or a social worker in your community would be available to work psychologically with some of the alcoholics, individually or in groups, it might be a great help in dealing with increasing numbers if the physician and the social worker and the psychologist were willing to work together.

In Illinois, social workers and psychologists are probably dealing with as many, if not more, alcoholic patients who are in the state program than physicians are directly.

The people who are actually seeing and interviewing the alcoholic patients in the Illinois programs are primarily non-medical. This is not a temporary situation. It is not going to disappear in the next five or ten years. If anything, more and more clinical responsibility will be discharged by the social workers and psychologists.

The author proposes that we learn to work with them, to not discourage them, but to find out what they can do and how they can help us in these huge mental health problems.

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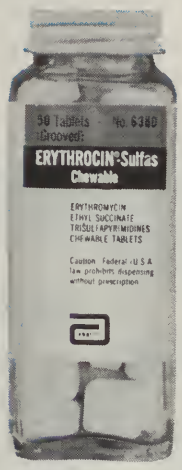
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1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

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Brief Summary on next page

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Elijah Saunders, MD—*Editor*

Rheumatic Fever: A Changing Approach to Secondary Prevention

LEON GORDIS, MD, MPH
Chairman, Rheumatic Fever Committee
Maryland Heart Association

Although the specific mechanisms involved in the pathogenesis of rheumatic fever are still unknown, the demonstration that all attacks of rheumatic fever occur as sequelae to antecedent streptococcal infections has provided the basis for an intelligent approach to both primary and secondary prevention. When first sulfa and then penicillin were added to our therapeutic armamentarium, it seemed likely that rheumatic fever recurrences would soon become a thing of the past. Today, however, over twenty years later, recurrences of rheumatic fever are unfortunately very much with us and at a large pediatric hospital in Baltimore, for example, recurrent attacks still comprise 11% of the total admissions for rheumatic fever.

Such recurrences are of great concern for several reasons. In the first place, an attack often carries with it a hospitalization with its attendant emotional trauma, educational deprivation and financial cost for the patient, his family and community. However, recurrences of rheumatic fever are also important from another viewpoint: Acute rheumatic fever is a far milder disease today than it was 20 years ago, and first attacks are rarely followed by severe rheumatic heart disease. *Most cases of incapacitating rheumatic heart disease today result from recurrent attacks of rheumatic fever.* Since rheumatic heart disease is the only permanent physical disability resulting from rheumatic fever, recurrences are a prime concern in any program aimed at prevention and control of this disease.

Role of the Maryland Heart Association

For over ten years, the Maryland Heart Association has provided penicillin to rheumatic patients for continuous prophylaxis against recurrent attacks. This program was initiated as a project to demonstrate the effectiveness of such a regimen in reducing the frequency of recurrences in rheumatic patients. The value of prophylaxis is now widely accepted. It has become increasingly clear, however, that the mere provision of the drug is not sufficient to engender patient cooperation. Indeed, prevention of recurrent attacks of rheumatic fever shares a number of the problems inherent in the management of many chronic diseases. The difficulties are often even greater in rheumatic fever since the patient is frequently asymptomatic after his acute attack and cannot accept the fact that he is at high risk for a recurrence unless he adheres to a preventive regimen. Several studies have shown that a large percentage of patients who begin on prophylaxis stop taking their drug within a short period of time.[1, 2] It is therefore apparent that the provision of medication must be coupled with an effective program of follow-up of delinquent patients.

With these considerations in mind, the Mary-

land Heart Association has undertaken a revision of its secondary prevention program. The changes to be described were initiated over a year ago and at the present time are still being developed and put into action. Briefly, these changes are as follows: The Heart Association no longer buys penicillin. Instead, the Association and the Maryland Pharmaceutical Association have agreed on a plan under which member pharmacists sell penicillin at low cost to patients certified as rheumatic by the Heart Association.

A second change has been the conversion of the Heart Association Registry to electronic data processing. Each month the Registry punch-cards are sorted for patients due back for penicillin. When a patient goes to a pharmacy to have a new prescription filled, the pharmacist sends in a card reporting the fact. These cards are subsequently matched with those of the patients who are due back during a given month. We are thus able to obtain a "print-out" of delinquent patients each month. We are now in the process of arranging for print-outs of delinquent patients by clinic in the hope that if each clinic is so notified, it can take action to restore these patients to medical supervision. We are also exploring the feasibility of utilizing a monthly list of delinquents in Baltimore City by health district and, in the rest of the State of Maryland, by county. If such a list included the school attended by delinquent rheumatic children, it would enable public health nurses in the districts and in the schools to follow up on all delinquent patients. Revisions of this type are being made to enable the registry to serve as an aid to regular community agencies in the follow-up of patients who have stopped their prophylaxis.

The Heart Association has also been examining its own role in the actual follow-up of rheumatic patients. The possibility of having a staff member coordinate follow-up activities on a community-wide basis is being carefully considered.

Verification of New Cases

In 1965, a procedure was instituted by which all new cases referred to the Heart Association Registry are verified by a Heart Association physician who reviews the clinical features reported on the referral form. Physicians are now also being encouraged to register as rheumatic suspects all patients in whom the diagnosis of rheumatic fever is in doubt. These physicians will be notified six months to a year after the referral has been made that they had referred a suspect case to the Registry and that perhaps re-evaluation and final disposition are in order.

This process of verification is important not only from the standpoint of patient welfare, but also from that of the clinical data being gathered. The statistics from the Registry do not give the incidence of the disease in our community since, on the one hand, a significant number of cases are not reported to the Registry and, on the other, some cases may have been over-diagnosed. Nevertheless, the data provided by the Registry do give us minimum-incidence figures for the community and also provide a changing clinical profile of rheumatic fever from year to year. Although it is too early to report on the clinical data for the first year of the revised Registry operation, it is interesting to note that 521 new referrals were made to the Rheumatic Fever Registry during 1966. Of these, 165 were for definite new attacks, and 7 for suspect new attacks. These figures represent minimum incidence, and indicate the problem of rheumatic fever is very much with us.

Other Problems

The changes in the Registry operation that have been briefly described here are intended to improve the follow-up of patients who have had rheumatic fever. The effectiveness of these modifications, however, will be governed in large measure by other factors which pose major limitations to secondary prevention programs. We have referred to the fact that several studies have reported that most rheumatic patients discontinue prophylaxis within a few years after their attack An equal cause for concern is the fact that, even among patients who remain on prophylaxis programs, there is a significant lack of compliance with medical recommendations.[3, 4, 5] Several factors may play a role in this non-compliance. In the first place, most patients with rheumatic fever are asymptomatic. Secondly, rheumatic fever, which has been called a social disease, occurs most frequently in lower socioeconomic groups. Families in these groups are often faced with complex psycho-social problems and may indeed be more concerned with their subsistence from week to week or even day to day than they are with taking oral penicillin, the reasons for which

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they cannot completely comprehend. Traditional specialty clinic care is often not equal to the problem of maintaining chronically ill patients on long term therapy. Indeed, categorical programs that concentrate on one disease to the exclusion of all others are inconsistent with modern medical aims at treatment of the whole patient.

Since rheumatic fever generally occurs during childhood or adolescence, it often has profound effects on the delicate processes of physical and emotional growth and development. The care of the rheumatic child in our clinics must therefore be integrated into the total pediatric or adolescent care he requires. Parents are more likely to follow through on recommendations for continual prophylaxis when they recognize that for any of their child's problems they can turn to the same physician who has a deep interest in their child's total physical, emotional and social adjustment. The individual attention sensed by both parent and child may foster greater compliance with medical recommendations and may indeed result in more successful prevention programs.

The changes made in the Maryland Heart Association Rheumatic Fever Registry represent only first steps, designed to improve the follow-up of rheumatic patients. These steps, however, must be followed by increased knowledge and understanding of our patients, of their needs, and of their aspirations, so that the medical care they receive can be made more consistent with their needs. The periodic evaluation of the rheumatic patient must be made in the context of total patient care. By coupling this approach with increased efforts in health education, we will begin to bridge the gaps in our present secondary prevention program.

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DEPARTMENT OF HEALTH
STATE OF MARYLAND
William J. Peeples, MD, MPH, Commissioner

HIGHLIGHTS

Statewide Measles Immunization Campaign

In a joint effort to eradicate measles in Maryland, the Medical and Chirurgical Faculty and the State Health Department will sponsor, in May, a mass campaign throughout the State to vaccinate children aged one through nine against this disease. It is estimated that some 150,000 children in this age group are susceptible to measles.

The Medical and Chirurgical Faculty is contributing the funds for educational and publicity materials, participating in the statewide organization of the campaign, and encouraging component societies to foster their own local campaigns and to man the clinics with necessary physicians. The State Health Department is assisting in organization and technical direction.

Local health departments, in cooperation with county medical societies and the Baltimore City Medical Society, are responsible for local organization in each campaign and for conducting the clinics. St. Mary's County will not participate in the May campaign because a mass immunization program was conducted there earlier in the year: despite bad weather and poor road conditions, approximately 1,300 children in the county received measles vaccine on February 12.

The US Public Health Service will provide vaccin for pre-school children in the May program. Costs for vaccine to be administered to older children will be defrayed by voluntary contributions of one dollar per child from the parents of all children who are vaccinated. Inability to pay will not preclude the vaccination of any child, however.

Members of the Junior Chamber of Commerce have volunteered to help in the campaign wherever they may be needed.

The Wennberg Report

The Department-sponsored sampling survey of 338 welfare-certified patients in 19 Baltimore nursing homes that have 50% or more of their beds occupied by welfare-certified patients was the work of John Wennberg, MD, graduate student in the School of Hygiene and Public Health, The Johns Hopkins University.

Findings of the study documented what has been obvious for many years—that too many elderly persons must live their remaining lives under conditions less than tolerable.

It is fruitless for specialized groups—whether physicians, hospitals, nursing home operators, or public health personnel—to point accusing fingers at one another. The problem is complex and requires total effort on all sides to combat it.

The situation derives to a large extent from social changes: increased longevity, increased percentage of the aging population, less spacious living accommodations, scarcity of household help, rising costs of living, difficulties of caring for the often incontinent and confused aging person, educational needs of youth, and last—but by no means least—the increasing burden on the physician who now is seldom in a position to serve as the "family doctor" of yesteryear.

Money will help, but is only a partial answer.

Solution to the problem lies in increasing general awareness and concern for the aged ill, so that they may receive not only proper medical care, but attention to their personal comforts and lonely state as well.

A copy of the Wennberg report is available, upon written request to the Department, to anyone wishing to acquaint himself with its findings.

Private Clinical Laboratory Directors

The registration of clinical laboratories in Maryland, now required by law, shows that of 65 private clinical laboratories outside of hospitals, 24 are headed by 15 Board-certified pathologists, 17 by 15 physicians other than pathologists, and 24 by 9 nonmedical doctors. Approximately 50% of the total number of tests were performed in laboratories directed by pathologists.

Billing for Aged Medical Assistance Patients

Physicians treating patients 65 years of age and over, who are certified under the Maryland Medical Assistance Program, may now use a single billing form to list all charges. The bill is sent to Blue Shield, which separates the Federal from the State portion and notifies the respective agencies of the amount owed by each.

This simplified procedure is the result of a coordinated effort by the Department, Blue Shield, and the Social Security Administration to ease the paperwork of the physician. It will also facilitate keeping the record of payments to physicians for services to elderly patients under the Medical Assistance Program, so that these payments are properly credited against Medicare's $50 deductible and 20% co-payment features.

The only exceptions to this procedure would be in the rare cases in which services are not included in the Medicare program, but are covered by the Medical Assistance Program.

Information on the revised billing method has been mailed to all Maryland physicians. Inquiries may be directed to Mr. John E. Welsh, Medical Services Division, 837-9000, Extension 8373.

New Vaccination Certificate

A new International Vaccination Certificate must be used for any person vaccinated after Jan. 1, 1967. The traveler may obtain the certificate from his travel agency or passport office, and should fill in the front page before presenting it to his physician.

After performing the vaccination, the physician must note the date of vaccination, the fact that a liquid or freeze-dried vaccine was used, the manufacturer's name, and the control or lot number, and he must sign the certificate. The traveler is responsible for having the certificate validated by the health department.

The certificate, which is in the form of a booklet, also provides space to record a brief health history of the traveler, including other immunizations, blood type and group, allergies, lens specifications, and other physician's notes that might be helpful if medical treatment is needed abroad.

Biochemistry Division Relocates

Pending construction of badly needed new laboratory facilities, the Biochemistry Division has moved to remodeled quarters at 22nd and Charles Streets. The relocation permits expansion of its functions to include screening tests and methodology development and training. The vacated quarters will be used for virologic examinations and will allow proper space for an electron microscope for rapid diagnosis of epidemic viral infections and other studies.

Communicable Disease Reports for 1966

Reports received during 1966 reflect the changing patterns in Maryland of all communicable diseases but **tuberculosis,** which remains at the fairly constant level of about 1,200 cases each year. Difficulties in locating undiscovered cases and securing patient cooperation in follow-up care are chiefly responsible for the continued high incidence of tuberculosis among the elderly and those in the lower socioeconomic groups.

Venereal disease continues to show an increase, although this may reflect improved reporting by physicians of the cases received for treatment. There were 575 cases of primary and secondary syphilis reported throughout the state, and 7,612 cases of gonorrhea. It is estimated that these figures represent less than a third of the actual incidence. There is little hope that venereal diseases will be brought under control until every case is reported promptly.

Reported **hepatitis** cases, 95% the infectious type, increased by 186 to a total of 833. Incidence of **measles,** quite prevalent during the first half of the year, when 85% of the cases were reported, fell off to almost zero by December. The intensified immunization campaigns to be conducted in May are expected to reduce the



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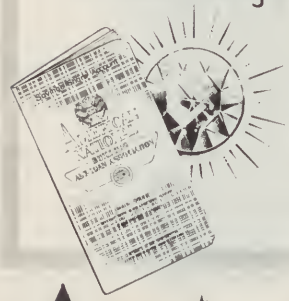
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Learn To Do Your Part In The Prevention Of Disease

Tuberculosis Task Force Holds First Meeting

The Baltimore City Tuberculosis Task Force, a new group established to aid Baltimore City's fight against tuberculosis, held its first meeting on February 28. David Marine, MD, chief of medical services, Loch Raven VA Hospital, is chairman of the Task Force and Allan S. Moodie, MB, DPH, administrative health officer for tuberculosis control, Baltimore City Health Department, is secretary. Others who attended the first meeting included Edmund G. Beacham, MD, chief, Tuberculosis Division, Baltimore City Hospitals; Leon Hetherington, MD, chief, Division of Respiratory Diseases, Maryland State Department of Health; and Frank Jones, executive director, Maryland Tuberculosis Association. Also attending were the following staff members from the Loch Raven VA Hospital: Perry Austin, MD, chief, Outpatient Service; Young Chun, MD, Medical Service; and Martin Land, chief, Medical Administration Service.

The Baltimore City Health Department was represented by James E. Peterman, MD, MPH, director, Bureau of Communicable Diseases; C. Gottfried Baumann, MD, MPH, health officer, Western Health District; Meyer Jacobson, MD, clinical director; Moses Shiling, MD, director, Tuberculosis Surveys; Miss Alice Sundberg, director, Public Health Nursing; and the Rev. Harry E. Shelley, LLB, coordinator of Alcoholism Programs. James M. McDiarmid of the US Public Health Service attended the first organization meeting as an observer. William Newcomer, MD, superintendent, Mt. Wilson State Hospital, and Wilson M. Wing, MD, MPH, administrative health officer, Eastern Health District, were unable to attend.

The Baltimore City Tuberculosis Task Force will meet regularly to discuss problems dealing with diagnosis of disease, treatment in hospitals and clinics, and supervision of patients residing in the city. The group will also serve as an advisory body to the City Health Department's Bureau of Communicable Diseases and give direction for a more uniform coordinated attack against this disease that affects the lives of about 4,000 city residents and their families and is estimated to cost the taxpayer in excess of $2,500,000 yearly.

Addison W. Pope, MD, Joins Department

Addison W. Pope, MD, has joined the Baltimore City Health Department as associate director of Mental Hygiene Services, an appointment made possible by Isadore Tuerk, MD, commissioner of the State Department of Mental Hygiene.

Dr. Pope has an extensive background of psychiatric practice in Baltimore. He served his internship at Provident Hospital and completed his psychiatric residency at the Psychiatric Institute of the University of Maryland. He is a clinical instructor in psychiatry at the University of

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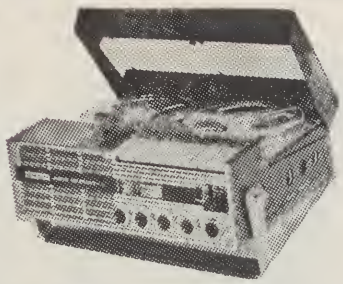
In his present position, Dr. Pope will plan mental hygiene services for Baltimore City and integrate the programs of the State Department of Mental Hygiene with the City Health Department's Bureau of Mental Hygiene and city mental hygiene facilities. Dr. Pope will also be concerned with developing more mental health facilities in Baltimore, particularly those offering services to adults.

Robert E. Farber, MD
Commissioner of Health

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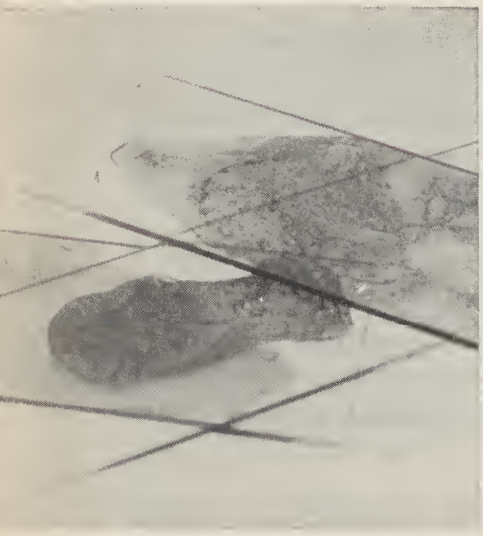
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Each capsule contains tetracycline phosphate complex equivalent to tetracycline hydrochloride 250 mg. and nystatin 250,000 un

A Building Block approach to treating hypertension

With these three therapeutic building blocks you can create a once-a-day regimen to fit almost any degree of hypertension. See the following pages for details . . .



Consider starting your hypertensives on this basic thiazide

Enduron eliminates sodium around the clock, yet is relatively sparing of potassium

Enduron is a true 24-hour single-dose thiazide. Its sodium excretion is not squeezed into an abrupt peak during the first several hours. It is well-sustained in a plateau-like effect — with little reduction in intensity during the first 12 hours, and decline thereafter only gradual.

Potassium loss, in contrast, reaches an early minor peak. Then it subsides rapidly. Moreover, doses larger than 5 mg. have little added effect on potassium. Thus doubling the dose from 5 to 10 mg. approximately doubles sodium excretion—yet increases potassium loss little or none.

Use Enduron once a day as an ideal starting therapy in mild hypertension. Use it, too, as a basic therapeutic building block with which other agents can be joined, for managing your more resistant hypertensives.

Once a day, every day

ENDURON®
METHYCLOTHIAZIDE



DAILY DOSAGE RANGE	Minimum	Usual	Intermediate	Maximum
	2.5 mg. tablet	5 mg. tablet	7.5 mg.	10 mg.

See Brief Summary on final page of advertisement.

To build added response, shift to Enduronyl

The deserpidine component compares favorably to reserpine, but with reduced side effects

The rauwolfia component of Enduronyl is deserpidine (Harmonyl®), a purified crystalline alkaloid. It is comparable to reserpine in its antihypertensive and tranquilizing activity. Yet it produces less tendency toward typical rauwolfia side effects such as drowsiness, lethargy, stuffy nose, depression, etc.

Patient acceptance has been excellent.

Enduronyl comes in two strengths: regular and Forte. Both provide 5 mg. of Enduron. The variation is where most needed: in the deserpidine. These scored tablets give a surprisingly flexible choice of doses (see below).

Use Enduronyl for your patients within the broad range of mild to moderate hypertension. Dosage is *once* a day: this means Enduronyl will generally cost patients less than equivalent drugs taken two or three times daily.

Once a day, every day

ENDURONYL®

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.25 MG.

ENDURONYL FORTE

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.5 MG.



	Minimum	Usual	Intermediate	Maximum
DAILY DOSAGE RANGE	2.5 mg. methyclothiazide 0.125 mg. deserpidine	5 mg. methyclothiazide 0.25 mg. deserpidine	7.5 mg. methyclothiazide 0.375 mg. deserpidine	10 mg. methyclothiazide 0.5 mg. deserpidine
DAILY DOSAGE RANGE	2.5 mg. methyclothiazide 0.25 mg. deserpidine	5 mg. methyclothiazide 0.5 mg. deserpidine	7.5 mg. methyclothiazide 0.75 mg. deserpidine	10 mg. methyclothiazide 1 mg. deserpidine

See Brief Summary on final page of advertisement.

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Eutonyl affords a different kind of basic therapy for moderate to severe cases

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Effect tied to reduced peripheral vascular resistance; no central depressant action

Eutonyl is a unique nonhydrazine agent. It is reported to act by reducing peripheral vascular resistance, with little or no effect upon cardiac output.[1,2]

In clinical trials, significant reductions in mean blood pressure were seen in 84% of patients studied — including some unusually difficult cases. Eutonyl lowers diastolic in proportion to systolic, and in half of the cases studied, reductions in the sitting and recumbent positions were nearly as great as in the standing position.

Most important: There is no central depressant action. In fact, many patients reported an *increased* sense of well being.

Here, then, is a highly effective *basic treatment* for moderate to severe cases—and one that will not hamper your patient with lethargy or drowsiness while on treatment.

Once a day, every day

EUTONYL®
PARGYLINE HYDROCHLORIDE



DAILY DOSAGE RANGE	Minimum	Usual starting	Intermediate	Maximum
	10 mg. tablet	25 mg. tablet	50 mg. tablet or as needed	200 mg.

1. Brest, A. N., et al., Cardiac and Renal Hemodynamic Response to Pargyline, Ann. N. Y. Acad. Sci., 107-1016, 1963.
2. Winsor, T., Pargyline Hydrochloride, Hypertension, Urinary Tryptamine, and Vascular Reflexes, Geriatrics, 19:598, Aug., 1964.

See Brief Summary on final page of advertisement.

Eutron adds thiazide for enhanced therapy with milder side effects

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Only a 7/4 mm. span between standing and recumbent pressures—reduced chance of orthastatic hypotension

The combining of Eutonyl and Enduron in Eutron permits a significantly greater antihypertensive effect than with either agent used alone. This in turn may allow therapeutic success with lesser dosage—and correspondingly milder side effects.

Indeed, fully 94.5% of all patients studied during clinical trials continued on therapy uninterrupted by side effects.

Most striking was the drug's action in lowering blood pressure to *nearly equal levels in all body positions.* Total average spread between standing and recumbent readings (after treatment) was only 7/4 mm. Hg.

Thus, in your moderate to severe cases, Eutron affords a usually smooth course of therapy, with reduced likelihood of orthostatic effects. And, because of the thiazide component, Eutron may be used in the presence of congestive heart failure.





Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 MG.
WITH METHYCLOTHIAZIDE 5 MG.

	Minimum	Usual starting	Intermediate	Maximum
DAILY DOSAGE RANGE	12.5 mg. pargyline hydrochloride and 2.5 mg. methyclothiazide	25 mg. pargyline hydrochloride and 5 mg. methyclothiazide	37.5 mg. pargyline hydrochloride and 7.5 mg. methyclothiazide	50 mg. pargyline hydrochloride and 10 mg. methyclothiazide

See Brief Summary on final page of advertisement.

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ENDURON®

METHYCLOTHIAZIDE

ENDURONYL®

Each tablet contains Methyclothiazide 5 mg.
with Deserpidine 0.25 mg. or 0.5 mg.

Indications: Enduron is used to control edema and mild hypertension. Also used with other drugs for hypertension. Enduronyl is used in mild to moderately severe hypertension.

Contraindications: Neither Enduron nor Enduronyl should be used in severe renal disease (except nephrosis) or shutdown; in severe hepatic disease or impending hepatic coma; in patients sensitive to thiazides. Enduronyl is contraindicated in severe mental depression, active peptic ulcer, and ulcerative colitis.

Warnings: Consider possible sensitivity reactions in patients with a history of allergy or asthma. Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small bowel lesions; if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical.

Precautions and Adverse Reactions: Use thiazides with caution in severe renal dysfunction. Caution is also necessary with impaired hepatic function or progressive liver disease. During intensive or prolonged thiazide therapy, watch chloride and potassium levels (especially the latter if patient is on digitalis). In surgical patients, thiazides may alter response to vasopressors and tubocurarine. Use thiazides with caution in pregnancy (bone marrow depression, thrombocytopenia, or altered carbohydrate metabolism are possible in certain newborn). Occasional thiazide side effects also include blood dyscrasias; elevations of BUN, serum uric acid, or blood sugar; electrolyte imbalance, g.i. disturbances, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, pancreatitis, and gout.

Use Enduronyl with caution in patients with a history of peptic ulcer, as rauwolfias may increase gastric secretion. Discontinue at the first sign of mental depression. Rauwolfias may increase hypotensive effects of surgery or anesthesia, and are best discontinued two weeks prior. They also lower the convulsive threshold in epilepsy. Other possible rauwolfia side effects include drowsiness, nasal stuffiness, nausea, weight gain, and diarrhea. Less frequent complications of deserpidine therapy are aggravation of peptic ulcer, epistaxis, and skin eruption. Alcohol, barbiturates or narcotics may potentiate action of deserpidine.

EUTONYL®

PARGYLINE HYDROCHLORIDE

EUTRON™

Each tablet contains Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications: For treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. Not recommended for use in patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone.

Contraindications: Pheochromocytoma, advanced renal disease, paranoid schizophrenia and hyperthyroidism. Until further experience is gained, not recommended for use in patients with malignant hypertension, children under 12, or pregnant patients.

Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. Interval of two weeks should separate therapy and use of these agents.

Warnings: Pargyline hydrochloride is a monoamine oxidase inhibitor. Warn patients against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When necessary to administer alcohol, narcotics (meperidine should be avoided), antihistamines, anesthetics, barbiturates, chloral hydrate and other hypnotics, sedatives, tranquilizers, or caffeine, these can be used cautiously at a dosage of ¼ to 1/5 the usual amount. Adjust dose of anesthetic agents to response of patient. Avoid parenteral administration where possible. Withdraw pargyline two weeks before elective surgery.

Warn patients about the possibility of postural hypotension. Those with angina or other evidence of coronary disease should not increase physical activity. Pargyline may lower blood sugar. Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions; if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical.

Precautions: Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver dysfunction or progressive liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields, and fundi.

During intensive or prolonged methyclothiazide therapy, watch chloride and potassium levels (especially latter if patient is on digitalis). Methyclothiazide also may reduce arterial response to pressor amines. Use thiazides with caution in pregnancy (bone marrow depression, thrombocytopenia, or altered carbohydrate metabolism are possible in certain newborns). Thiazide drugs may increase responsiveness to tubocurarine.

Side Effects: Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extra-pyramidal symptoms have been reported. Drug fever is extremely rare. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Thiazide side effects also include blood dyscrasias, elevation of BUN, serum uric acid, or blood sugar, electrolyte imbalance, g.i. disturbances, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, pancreatitis, and gout. Nocturia has been observed with the combination.

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MARYLAND ASSOCIATION OF MEDICAL ASSISTANTS

APRIL, 1967 PEGGY BURY, *Editor*

ANATOMY AND PHYSIOLOGY COURSE OFFERED BY BAMA

Beginning in February and ending this month, Jack Zimmerman, MD, conducted an eight-session course in anatomy and physiology. Given in the Keswick Home auditorium, the course was offered to all who were interested in attending the weekly lectures, but was directed particularly to the medical assistants who are studying for the certification examination given by the American Association of Medical Assistants.

Dr. Zimmerman is chief of surgery and director of medical education at Church Home and Hospital and associate professor of surgery at The Johns Hopkins University School of Medicine. A graduate of The Hopkins medical school, where he served both his internship and his residency, he accepted an appointment at the University of Kansas School of Medicine in 1959 as associate professor of surgery. During his tenure there he was also chief of surgery at the Kansas City Veterans Administration Hospital. In 1965, he returned to Baltimore to accept his present position at Church Home and Hospital and The Johns Hopkins University School of Medicine.

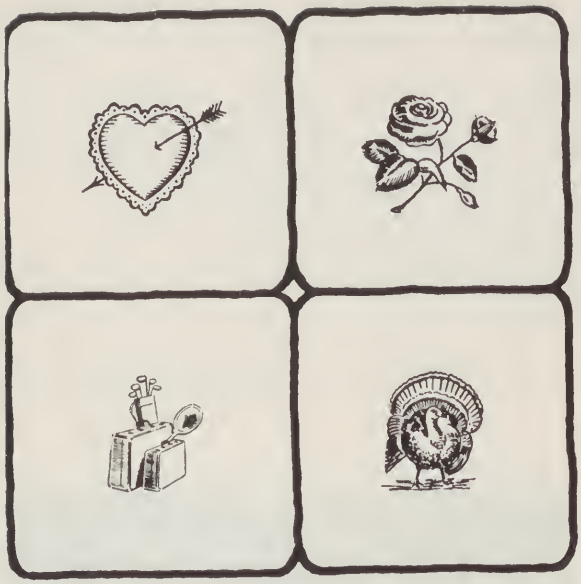


Jack McK. Zimmerman, MD

J. B. T. FOSTER, MD, ADDRESSES BAMA

At the March meeting of the Baltimore Association of Medical Assistants, J. B. T. Foster, MD, pathologist, spoke to the membership on clinical laboratory work. Following his short presentation, the members participated in an informal discussion of laboratory techniques, interpretation of test results, and preparation of patients before tests.

A graduate of Princeton University, Dr. Foster received his MD degree from New York Medical College and served his internship at Bellevue Hospital. Following residencies at St. Luke's Hospital and Lenox Hill Hospital, he served in the US Navy at Jacksonville Naval Hospital. He then became associate pathologist at Doctor's Hospital, NY, and assistant medical examiner for New York City. After serving as Director of Labora-



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tories and Pathologist at St. Joseph's Hospital, Yonkers, NY, Dr. Foster came to Baltimore to enter private practice as an associate of H. L. Wollenweber, MD.

"OUTSTANDING YOUNG WOMEN OF AMERICA" HONOR MEDICAL ASSISTANT

Gertrude Gillum, vice-president of the Maryland Association of Medical Assistants, was selected to appear in the 1966 edition of "Outstanding Young Women of America." Mrs. Gillum was one of four women from Allegany County chosen for this honor. She is presently employed as senior medical secretary at Memorial Hospital, Cumberland, Md., under Frank Cawley, MD; George Mock, MD; and Robert Miller, MD, radiologists.



Mrs. Gertrude Gillum

Guidelines for selection of candidates for recognition include unselfish service to others, charitable activities, community service, professional excellence, business advancement and professional responsibility. Following notification of her selection by the board of the General Federation of Women's Clubs, Mrs. Gillum also received a congratulatory letter from US Senator Joseph D. Tydings of Maryland.

Woman's Auxiliary
MARYLAND
HYGEIA FILIAE
W A M C F

APRIL, 1967 MRS. HARRY L. BERMAN, *Editor*

State Auxiliary Members Invited to Attend June Convention of Woman's Auxiliary to the AMA

An invitation to attend the 44th Annual Convention of the Woman's Auxiliary to the American Medical Association on June 18-22 in Atlantic City, NJ, has been extended to all State Auxiliary members by Mrs. Asher Yaguda, of Newark, NJ, Auxiliary president. A block of rooms has been set aside at the Shelburne Hotel for Auxiliary members. Reservations should be made through the AMA Housing Bureau, 16 Central Pier, Atlantic City 08401. For preferential handling, reservations should be made early. A list of other hotels and motels appeared in the March issue of THE JOURNAL and will appear in spring issues of the *Journal of the American Medical Association* and the *AMA News*.

Mary Calderone, MD, noted proponent of sex education, is scheduled to talk on "Sex Education: Goals and Means" Tuesday morning, June 20. Also speaking on Tuesday will be Charles L. Hudson, MD, AMA president. He is to speak at the luncheon honoring Auxiliary past presidents and AMA officers and trustees. The Auxiliary's contribution to AMA-ERF will be presented at that time, as well as awards to county and state AMA-ERF winners.

Mrs. Yaguda and Mrs. Karl F. Ritter, Lima, Ohio, president-elect, will be honored at a reception Sunday, June 18. Mrs. Ritter will be installed as president Wednesday, June 21.

Other convention highlights will include the Monday Guest Day Luncheon (speaker to be announced) and "The Little Workshop," a question-and-answer session on Auxiliary programs. State auxiliary presidents will report on outstanding local programs at the Monday and Tuesday sessions.

The Auxiliary will also sponsor a teen-age program for children of physicians and guests attending the AMA convention.

HEALTH CAREERS CHAIRMAN REPORTS

The State organization of the Future Nurses of America held its annual meeting on April 22 in the Surrattsville Senior High School at Clinton, Md, according to a report from Mrs. Raymond M. Yow, Health Careers Chairman of the Woman's Auxiliary to the Faculty. The number of FNA clubs throughout the State has increased from 59 last year to 63 this year.

The Health Careers Committee of the Woman's Auxiliary to the Washington County Medical Society has visited every senior high school FNA club in the county; has entertained club officers and sponsors at a tea to which hospital representatives and nursing school directors were also invited; and has sponsored a Second Annual Health Careers Day, which encompassed visits to hospitals, addresses from professionals in various fields of health and the showing of a film entitled "Health Careers." The Washington County Auxiliary offered two scholarships this year, one of $600 for a student nurse and one of $65 for an X-ray technician student.

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tee has informed Mrs. Yow that there are nine FNA clubs in Anne Arundel County senior high schools and that the county Chamber of Commerce sponsors a semi-annual Career Night which includes a section on Health Careers.

BALTIMORE CITY

The Annual Meeting and Installation Luncheon of the Woman's Auxiliary to the Baltimore City Medical Society will be held at noon on Wednesday, May 10, at 1211 Cathedral Street. Mrs. Max R. English will be installed as president of the Society and other officers for the coming year will be elected during the business session.

Guest speakers at the luncheon will be Dr. and Mrs. Theodore Woodward, who will give an illustrated talk entitled "A Medical Mission to Pakistan."

MONTGOMERY COUNTY

The Woman's Auxiliary to the Montgomery County Medical Society, in celebration of Doctor's Day (March 30) distributed red carnations in the county hospitals on that day and entertained the doctors of the county at a cocktail dance on April 2. The dance was held at the Manor Country Club.



AMA BYLAWS

Chapter VI. Meetings-Section 2. Registration (A) Members. A Member's Section registration shall correspond with his specialty or General Practice status as designated by him for classification in the American Medical Association Directory. To be accepted for Section registration purposes, a member of a Section who desires to change his registration from one Section to another because of a change in his specialty, shall be required to inform the Headquarters of The American Medical Association by written notice of this intention at least sixty days in advance of the Annual Convention.

Chapter VII. Sections-Section 7. Participation in Business Only *active members* registered in accordance with Chapter VI, Section 2 (A) shall have the right to participate in the *business deliberation* of a section.

American Medical Association · 116th Annual Convention · Convention Hall ·

June 18-22, 1967 Atlantic City

PLEASE NOTE

An Active physician member may not change *his Section* registration for voting purposes from one Section to another Section, unless written notice of a change in his specialty has been given the AMA Headquarters at least 60 days (by April 18, 1967) in advance of the opening day of the Annual Convention.

Upon completion of an Active Member's Registration at the AMA Registration Desk, members will not be permitted to switch from one Section registration to another Section registration during the entire period that the AMA Annual Convention is in session.

However, all members are encouraged to attend any and all of the Scientific Section programs. Such attendance has no direct connection with the Section in which an Active Member may wish to be qualified to vote.

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In accordance with the AMA Bylaws, I hold active membership in the AMA and I wish to vote in the Scientific Section I have checked:

- ☐ Allergy
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- ☐ Laryngology, Otology and Rhinology
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- ☐ Obstetrics and Gynecology
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(Only Active Members Will Be Permitted To Vote)

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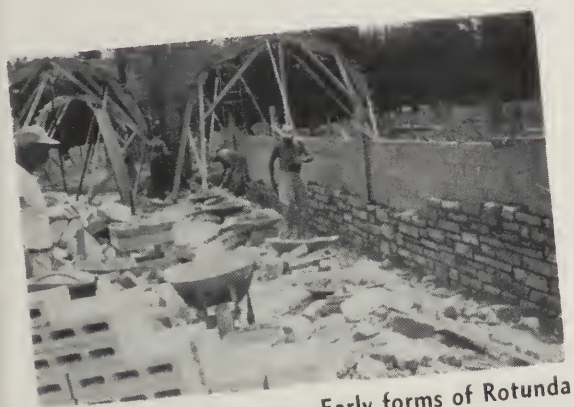
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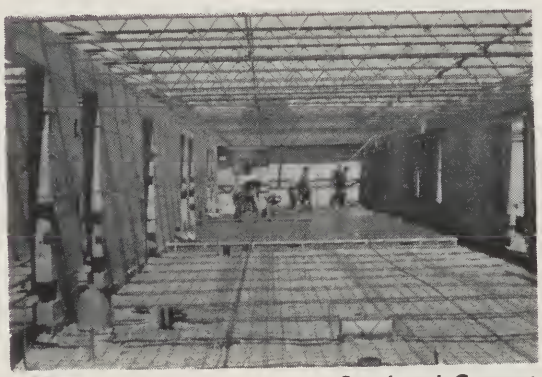
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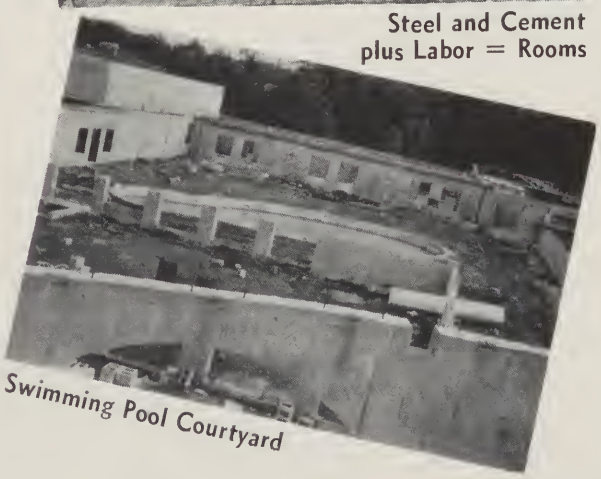
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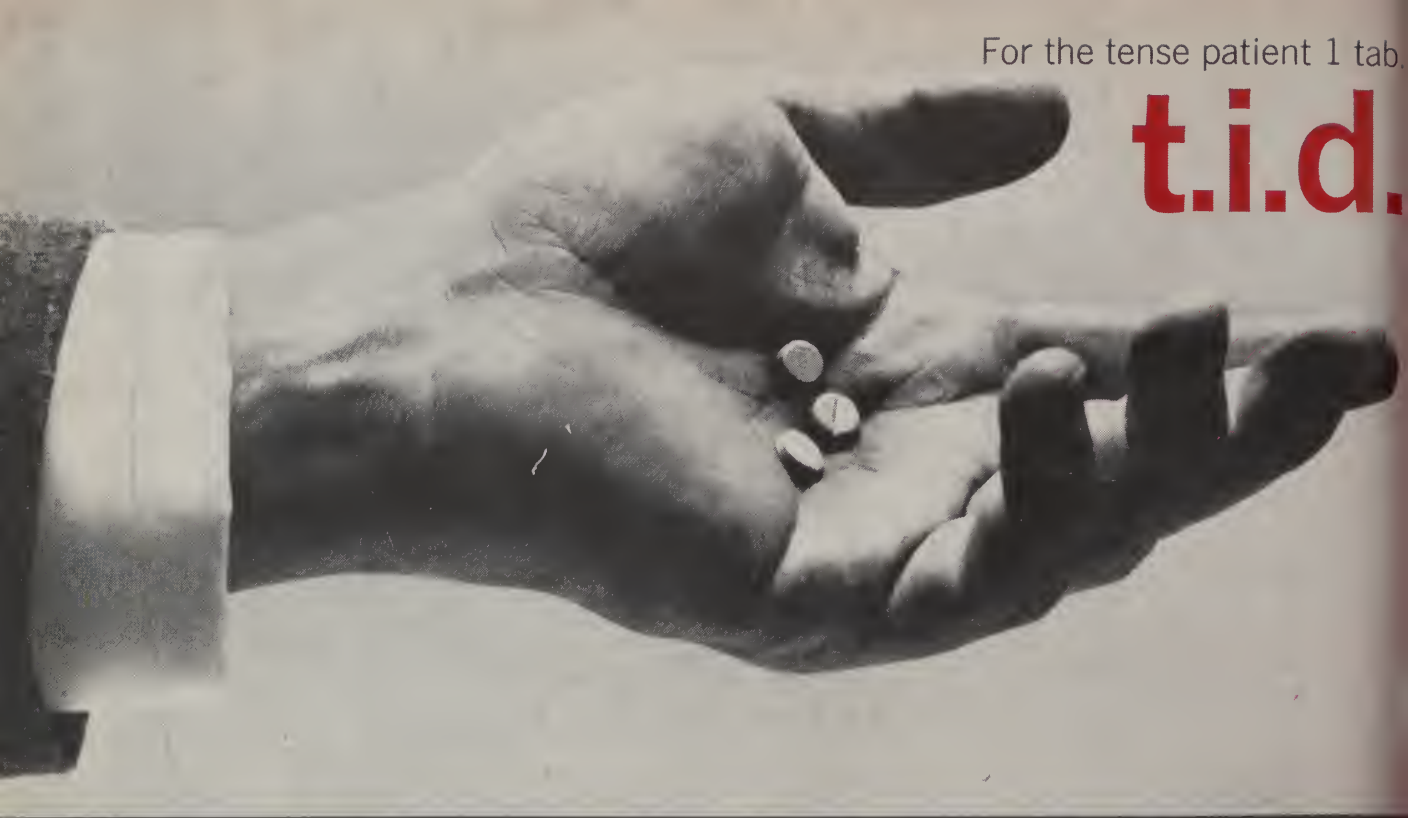
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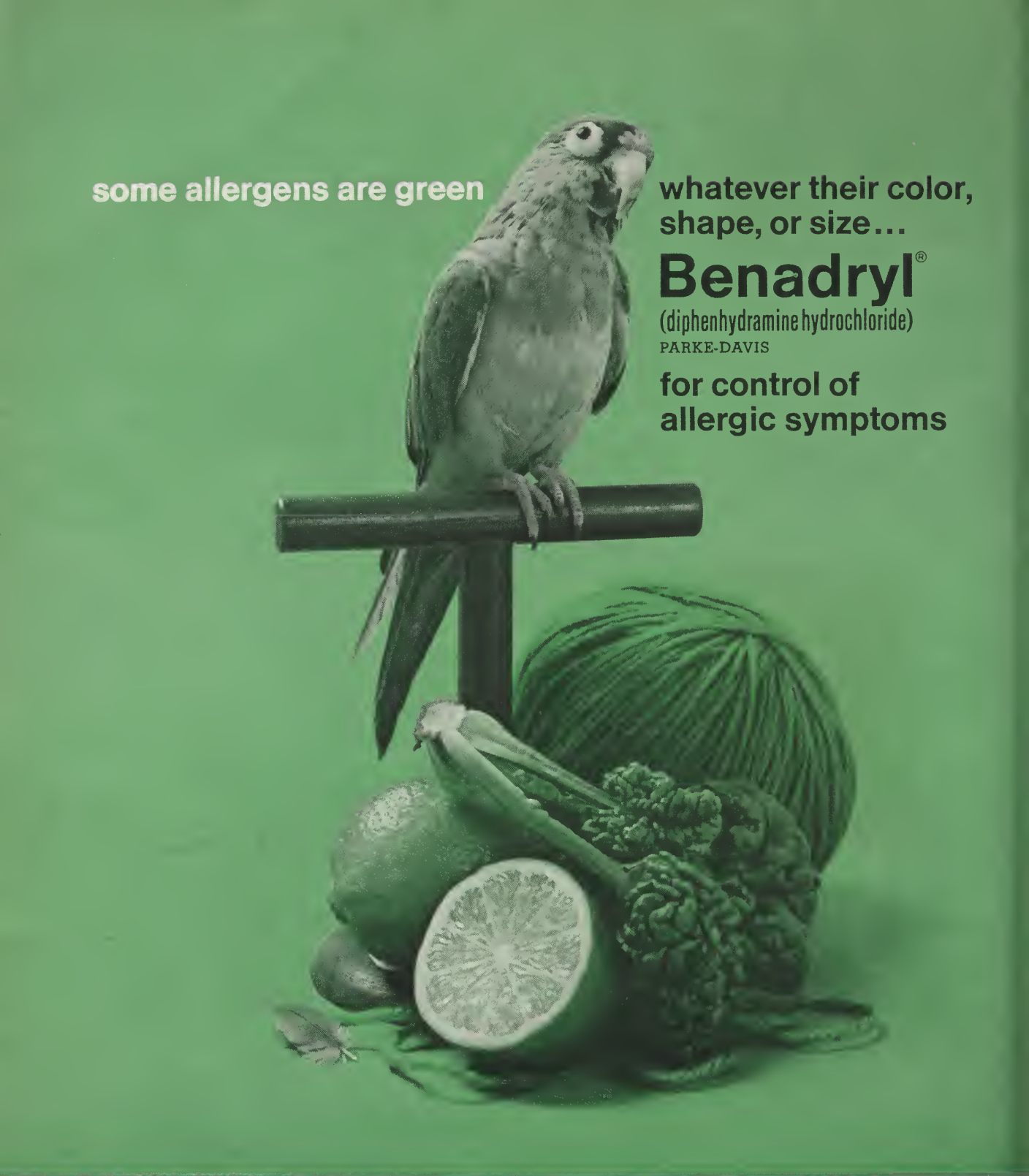
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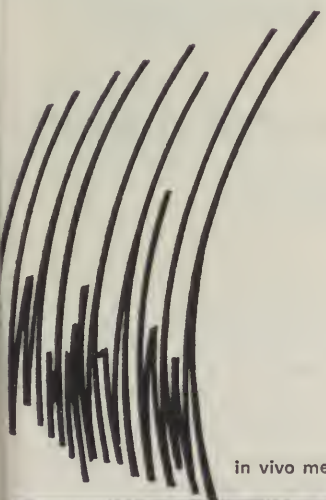
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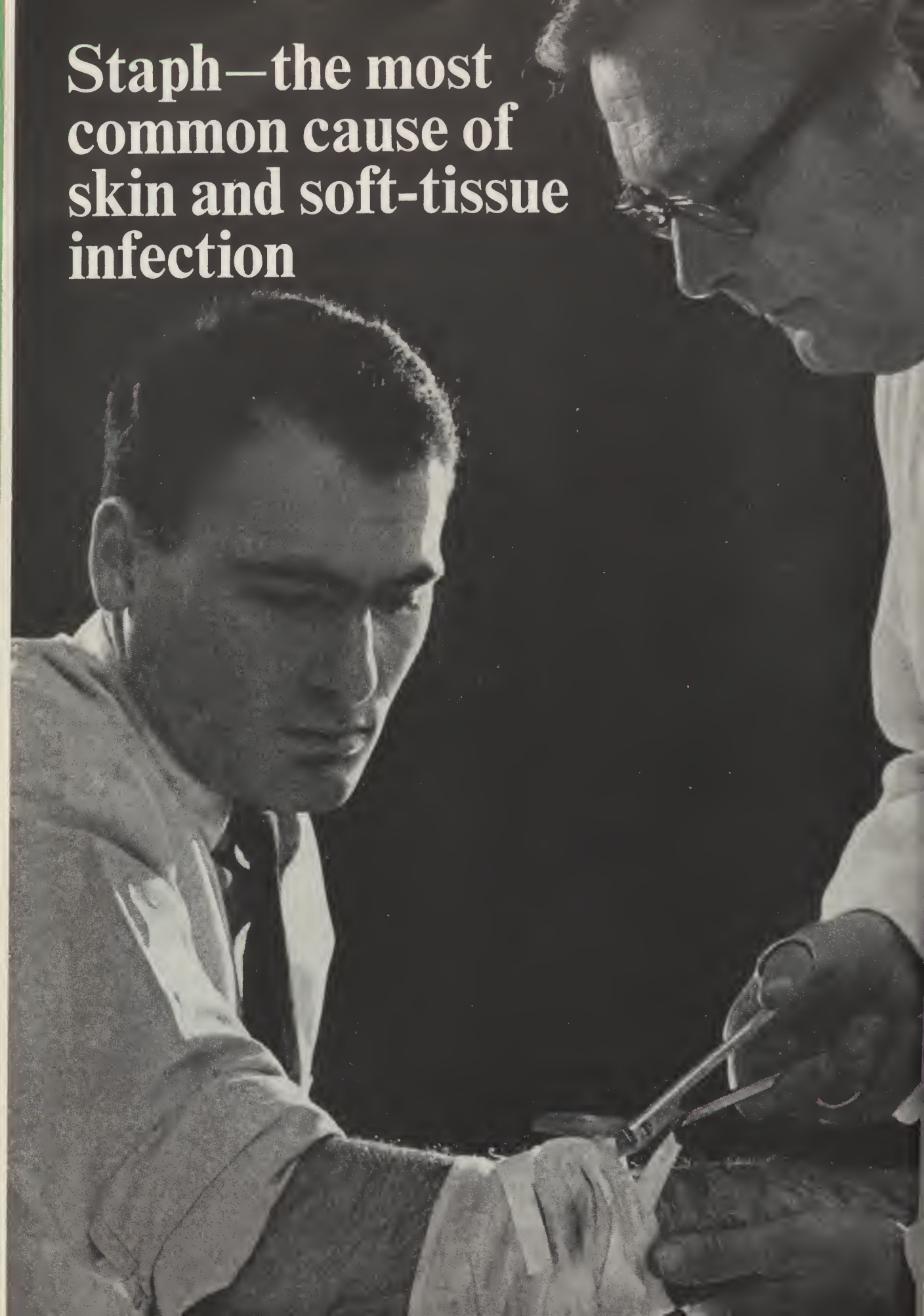
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Wilburn L. McClure, Jr.

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ph—the most common cause of skin and soft-tissue ection—also is responsible for many more serious ections, such as pneumonia, osteomyelitis, and ticemia. Often, a seemingly minor skin infection is source of metastatic spread to deeper structures. en findings on culture incriminate staph as the se, Prostaphlin (sodium oxacillin) will provide ific effective therapy.

tericidal effectiveness. Hardly a staph organism resist the bactericidal action of Prostaphlin (sodioxacillin), as shown by a 34-month *in vitro* study. ll staph isolates tested, 99.5% were sensitive to cillin.[1]

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Outstanding safety record. Besides being staph-specific and rapidly absorbed—Prostaphlin (sodium oxacillin) has established an outstanding record of safety during five years of widespread clinical use. Continuous high blood levels of oxacillin have not produced toxic effects on kidney function, assuring a significant margin of safety. However, as with all penicillins, the possibility of allergic response should be considered.

Capsules, Oral Solution and Injectable. Prostaphlin (sodium oxacillin) is available in three flexible dosage forms to suit the age of the patient and severity of infection—capsules, an oral solution for pediatric use, and multi-dose vials for injection, I.M. or I.V.

PRESCRIBING INFORMATION: For complete information, consult Official Package Circular. *Indications:* Infections caused by Staphylococci, particularly those due to penicillin G-resistant Staphylococci. *Contraindications:* A history of severe allergic reactions to penicillin. *Precautions:* Typical penicillin-allergic reactions may occur. Safety for use in pregnancy and premature infants is not established. Because of limited experience, use cautiously and evaluate organ system function frequently in neonates. Mycotic or bacterial superinfections may occur. Assess renal, hematopoietic and hepatic function intermittently during long-term therapy. *Adverse Reactions:* Skin rashes, pruritus, urticaria, eosinophilia, nausea, vomiting, diarrhea, fever and occasional anaphylaxis. Rare cases of reversible hepatocellular dysfunction have occurred. Moderate SGOT elevations have been noted. Thrombophlebitis has occurred occasionally during intravenous therapy and leukopenia was noted in two cases. *Usual Oral Dosage:* Adults: 500 mg. *q.*4 or *q.*6*h.* Children: 50 mg./Kg./day. *Usual Parenteral Dosage:* Adults: 250-500 mg. *q.*4 or *q.*6*h.* Children: 50 mg./Kg./day. Treat beta-hemolytic streptococcal infections for at least 10 days. Give oral drug 1 to 2 hours before meals. *Supplied:* Capsules—250 and 500 mg. in bottles of 48. Injectable—250 mg., 500 mg., and 1 Gm. dry filled vial for I.M./I.V. use. For Oral Solution—100 ml. bottle, 250 mg./5 ml. when reconstituted. **A.H.F.S. CATEGORY: 8:12.6**

References: 1. Abstracted from *Antibiotic Sensitivity of Staphylococci Studied from November 1962 through August 1965,* reported by Griffith, L.J., Staphylococcus Reference Laboratory, V.A. Hospital, Batavia, N.Y. 2. Data on file, Bristol Laboratories.

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JOHN SARGEANT — EXECUTIVE SECRETARY

ON APRIL 6, THE EXECUTIVE COMMITTEE:

1. Authorized the provision of legal defense, if needed for 1967 acts, to two physicians who had reliable reasons for late payment of 1967 dues. No suits are pending against these physicians.

2. Made various recommendations to the Governor in connection with appointments to:
Board of Physical Therapy Examiners
Advisory Council on Hospital Construction
Advisory Board on Hospital Licensing
Commission on Problems of the Aging
Maryland Hospital Commission

3. Authorized expenditure of funds for past-president plaques.

4. Authorized the Subcommittee on Maternal Welfare to study changes in the Abortion law, and report back as promptly as possible, but before the 1968 General Assembly convenes.

5. Authorized the Treasurer to purchase insurance for the Faculty in connection with the Mass Measles Immunization campaign.

6. Authorized the use of the Faculty addressograph plates for a flyer on the Constitutional Convention.

7. Endorsed a proposal of the Maryland Heart Association to ask an opinion from the Attorney General's office on nurse initiation (as a first-aid measure) of closed-chest resuscitation.

8. Approved an appointment to the Baltimore Criminal Justice Commission.

9. Authorized the Treasurer to sign a contract with the State Health Department in connection with the Mass Measles Immunization program, after clearing with legal counsel and checking for the accuracy of the terms involved.

10. Adopted the following statement as recommended by legal counsel:

"It is the well-established and commonly accepted medical practice and custom in this State to do inoculations by hand syringe from multiple dose vials and such practice and custom is in accordance with traditional standards of medical care ordinarily practiced not only in this State but by others in the profession generally."

ON APRIL 19, THE COUNCIL:

1. Approved a recommendation to the House of Delegates for Emeritus membership.

2. Ratified legal defense for physicians requesting it.

3. Recommitted to the Med-Chi Insurance Trustees a proposal for a members' retirement program with the suggestion that commercial proposals be considered as well.

4. Adopted the following statement dealing with Chiropractic:

It is the position of the medical profession that chiropractic is an unscientific cult whose practitioners lack the necessary training and background to diagnose and treat human disease. Chiropractic constitutes a hazard to rational health care in the United States because of the substandard and unscientific education of its practitioners and their rigid adherence to an irrational, unscientific approach to disease causation.

In 1965, a United States District Court, in upholding a state's constitutional right to refuse to license chiropractors, said that "since chiropractic claims to be a complete and independent healing art capable of curing almost all kinds of disease, the state Legislature may have felt that the re-

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Edith L. Taylor, Executive Director

IRVING J. TAYLOR, M.D., MEDICAL DIRECTOR

quirement of a foundation in materia medica and surgery . . . would be a protection to the public." Without dissent, the United States Supreme Court affirmed the decision.

The wisdom of these decisions by the nation's highest courts justifies the medical profession's educational program of alerting the nation to the public health threat posed by the cult of chiropractic.

Patients should entrust their health care only to those who have a broad scientific knowledge of diseases and ailments of all kinds, and who are capable of diagnosing and treating them with all the resources of modern medicine. The delay of proper medical care caused by chiropractors and their opposition to the many scientific advances in modern medicine, such as life saving vaccines, often ends with tragic results.

ON APRIL 19, THE HOUSE OF DELEGATES:

1. Honored deceased members of the Faculty in the previous year.

2. Received the 1967 budget, for information purposes only, and approved the auditor's report for the 1966 year.

3. Heard a report from the Treasurer that the Faculty had received the Walter R. Steiner, MD, Trust as remainderman, and an additional sum to be added to the Hundley Memorial Lecture Fund.

4. Approved Emeritus membership for:
H. Wayne Glickfield, MD, Prince George's County
Philip J. Hirshman, MD, Washington County

5. Heard Dean Thomas B. Turner discuss the Regional Medical Program for Heart Disease, Cancer and Stroke. Dr. Turner is scheduled to assume the post of coordinator of this program on July 1, 1967.

6. Adopted the following motion:
Resolved: That the sum of $15,600 be allocated from the Educational Fund of the Faculty for the continuation of the Medic Network for the period from July 1967 to July 1968.

7. Received the report of the Nominating Committee.

8. Saw the President honor the following Fifty-Year Members with the presentation of Fifty-Year pins:
Theodore H. Morrison, MD
George McLean, MD

9. Adopted various Bylaw amendments.

10. Received various Committee reports for information purposes.

11. Commended the Legislative Committee chairman for his extensive efforts during the 1967 General Assembly session.

ON APRIL 20, THE FACULTY MEMBERSHIP IN GENERAL SESSION:

Elected the following to the Board of Medical Examiners for a four-year term:

John H. Hornbaker, MD, Hagerstown
Frank K. Morris, MD, Baltimore

ON APRIL 21, THE COUNCIL:

1. Elected as Chairman, Russell S. Fisher, MD, and as Vice-Chairman, John F. Schaefer, MD.

2. Authorized the Council Chairman, the President and the Legislative Chairman to compose comments on a letter sent by the State Health Commissioner to the Governor with respect to Senate Bill 486 (providing for payments to Optometrists under the medical care program, and other changes in the law dealing with the operation of this program).

3. Approved the dispatch of the following telegram to WMAR-TV (Channel 2) in response to one profferring public service time for a debate on Chiropractic: "When Chiropractors elevate their standards to those of scientific medicine, we will be glad to debate with them."

ON APRIL 21, THE HOUSE OF DELEGATES:

1. Elected the following slate of officers, for terms as indicated, by unanimous consent:

President-elect
Arthur G. Siwinski, Baltimore—President-elect 1967-68; President 1968-69

First Vice-President
Henry A. Briele, Sailsbury

Second Vice-President
Wolcott L. Etienne, College Park

Third Vice-President
George O. Eaton, Batlimore

Secretary
William A. Pillsbury, Timonium

Treasurer
Karl F. Mech, Baltimore

Councilors
John M. Dennis, Baltimore, Central District (1971)



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Harry M. Robinson, Jr., Baltimore, Central District (1971)
Donald J. Roop, Baltimore, Central District (1971)
Raymond M. Yow, Salisbury, Eastern District (1971)
J. Parran Jarboe, La Plata, Southern District (1971)

Delegate to American Medical Association
J. Sheldon Eastland, Baltimore (Jan. 1, 1968-Dec. 31, 1970)

Alternate Delegate to American Medical Association
Robert C. Kimberly, Baltimore (Jan. 1, 1968-Dec. 31, 1970)

Committee on Program and Arrangements
John B. DeHoff, Baltimore (1972)

Library and History Committee
Robert B. Goldstein, Baltimore (1973)

Finney Fund Committee
Richard W. TeLinde, Baltimore (1973)

2. Heard the Treasurer advise that an additional sum had been presented to the Faculty for the George M. Boyer, MD, Lecture Fund.

3. Rejected, by a vote of 42-34, Resolution 1A/67, the subject of which was:

Condemning Attempts by Insurance Carriers to Determine Qualifications of Physicians; and Requesting That Such Carriers Amend Their Regulations to Prevent This:

4. Rejected Resolution 2A/67, the subjects of which were:

Authorizing the State Board of Medical Examiners, in Concert With Specialists, to Determine the Qualifications of Such Specialists; Providing for Election of the Board of Medical Examiners by Mail Ballot; Broadening the Powers of the Board of Medical Examiners to "Control and Regulate the Entire Practice of Medicine . . . in the State of Maryland"; and Making Other Recommendations Relating to Its Operation, Status and Composition; and Providing Certain Things That Are Now Governed By State Law or Regulation.

5. Rejected Resolution 3A/67, the subject of which was:

Closing of All Well-Baby Clinics and Transfer of Patients to Private Physicians.

6. Tabled Resolution 4A/67, the subject of which was:

Urging Faculty Members to Use the Democratic Processes for Correction of Impropriety in any Laws, Rules or Regulations; and Obey Any Such Laws Until They are Properly Changed.

7. Adopted, as amended, Resolution 5A/67, the subject of which was:

Reiteration of the Faculty's Policy to Assist the State Health Department in Maintenance of High Standards in Maryland's Title 19 Medical Care Program.

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8. Expressed concern over the funds provided in the Governor's Budget for the Title 19 Medical Care program, and reaffirmed its support of the program. The office was instructed to send the Governor a telegram to this effect, with a copy to the Senate President and House Speaker.

9. Recognized the absence of Walter N. Kirkman, Faculty Honorary Member, because of illness.

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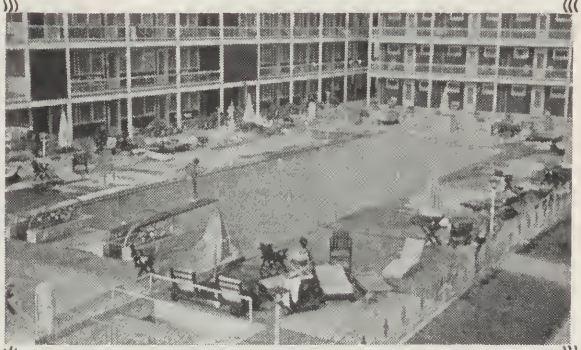
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Doctors take note...

CONCEPTION CONTROL

May 25-27

A seminar for Physicians, University Medical Center. Tution $25.00. Contact: Margaret Sanger Research Bureau, 17 West 16th St., New York, N. Y. 10011.

CLINICAL ELECTROENCEPHALOGRAPHY

June 5-7

A second course for physicians who have had little or no formal EEG training. Contact: Donald W. Klass, MD, EEG Course Director, Maya, Clinic, Rochester, Minn. 55901.

AMERICAN RHEUMATISM ASSOCIATION

June 15, 16

Annual Meeting—New York Hilton Hotel. Cantact: Miss Margaret M. Walsh, 1212 Avenue of the Americas, New York, N. Y. 10036.

SEABOARD MEDICAL ASSOCIATION

June 16-18

72nd Annual Meeting—Carolina Hotel, Nags Head. Contact: Jerome E. Adamson, MD, 603 Medical Towers, Norfolk, Va. 23507.

AMERICAN ASSOCIATION FOR THE STUDY OF HEADACHE

June 17

Ninth Annual Meeting at Colony Resort, Atlantic City, N. J. Contact: Seymour Diamond, MD 5214 North Western Avenue, Chicago, Ill. 60625.

116th ANNUAL AMA CONVENTION

June 18-22

General Scientific sessions on Patient Care, Backache, Healing, and Sex; symposia at individual or jaint meetings of the 22 Scientific sections; medical matian pictures; and live calar television programs. See JAMA May 8, 1967, for complete scientific programs, farms for advance registration and hotel accommadations.

AMA DEPARTMENT OF HEALTH EDUCATION

June 18—7:30 PM

Ninth Annual Pre-Convention session on Schaal Health. Chalfonte-Haddon Hall. Contact: Department of Health Education, Division of Socio-Econamic Activities, American Medical Associatian. 535 Narth Dearbarne St. Chicaga, Ill. 60610.

HEART ASSOCIATION OF MARYLAND

June 23-25

Week End with Doctors. Western Maryland College, Westminster, MD. Contact: 415 North Charles Street, Baltimore, MD. 21201.

THE AMERICAN DIETIC ASSOCIATION

August 14-18

Golden Anniversary Meeting. Conrad Hilton Hotel. Contact: The American Dietic Association 620 North Michigan Ave. Chicago, Ill. 60611.

OKLAHOMA CITY CLINICAL SOCIETY

October 2-4

37th Annual Fall Conference. Sheraton Oklahoma Hotel. Contact: Alma O'Donnell 2809 Northwest Expressway Oklahama City 73112.



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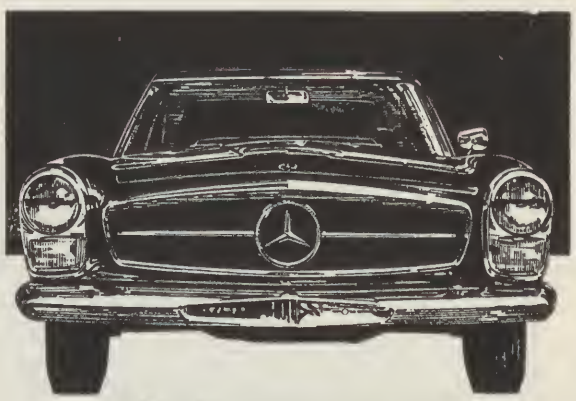
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EXECUTIVE SECRETARY'S NEWSLETTER

May, 1967

LAST MEETING OF JOHNS HOPKINS UNIT

The 50th and final reunion of the Johns Hopkins Unit (Base Hospital #18) of WW 1 will be held on Saturday, June 17, 1967, at the Sheraton-Baltimore Inn, Baltimore.

Master of Ceremonies for this occasion is E. R. Desch, Clearwater Beach, Florida.

PERSONALITIES

Charles S. Petty, M.D., is to become the new Professor of Forensic Pathology at the Indiana University School of Medicine.

Dean Thomas S. Turner, Drs. William S. Spicer and Edward S. Stafford are the Co-ordinator and Associate Coordinators of the Regional Medical Program for Heart Disease, Cancer and Stroke.

Murray M. Kappelman, M.D., Baltimore, will become the new full-time director of the Sinai-Druid Hill Comprehensive Pediatric Center.

CRUISE CONVENTION

Reservations are now being accepted for the 1968 Cruise Convention of the Faculty. The SS Argentina will leave Baltimore on Sunday, April 21, 1968, returning on Sunday, April 28. Calls will be made at San Juan, P.R., and St. Thomas, V.I.

Full details will be in the mail to all members shortly, or can be obtained through the Faculty office.

AMA SESSION IN ATLANTIC CITY

The AMA's Annual Session will be held in Atlantic City, N.J., starting on Sunday, June 18. The opening session will feature a program on Medicine and Religion at Convention Hall.

Topics under discussion will include the Unwed Mother - - Contraceptives and the Coed - - - Abortion - - - Alcoholism.

SELECTIVE SERVICE LOCAL MEDICAL BOARD ADVISERS SOUGHT

The Maryland State Selective Service System has issued a call for volunteer physicians to serve as local Medical Board Advisors. Interested persons should contact 752-8460, ex. 2031, or visit with Reginald C. Morrison, Deputy State Director, at the Fifth Regiment Armory, Room 10.

NEWS NOTES

Paul Bormel, M.D., Baltimore, has been named a Diplomate of the American Board of Urology.

Eugene I. Baumgartner, M.D., Oakland, has been named to the AMA's Council on Scientific Assembly.

John J. Walsh, M.D., Bethesda; and Paul V. Joliet, M.D., Kensington, have been selected to serve on the AMA's Committee on Emergency Medical Services.

Edmond J. McDonnell, M.D., Baltimore, has be been named to serve as representative of the American Academy of Orthopedic Surgeons; and William J. Peeples, M.D., Baltimore, has been designated as a representative of the American Association of Public Health Physicians; both to serve on the AMA's Interspecialty Committee.

SOCIETY ELECTIONS

Robert W. Gibson, M.D., Towson, has been elected President of the Maryland Psychiatric Society.

Edward Newby, M.D., is the new president of the Maryland Ophthalmological Society; while Irvin P. Pollack, M.D. is Vice-President; and David Paton, M.D., Secretary-Treasurer.

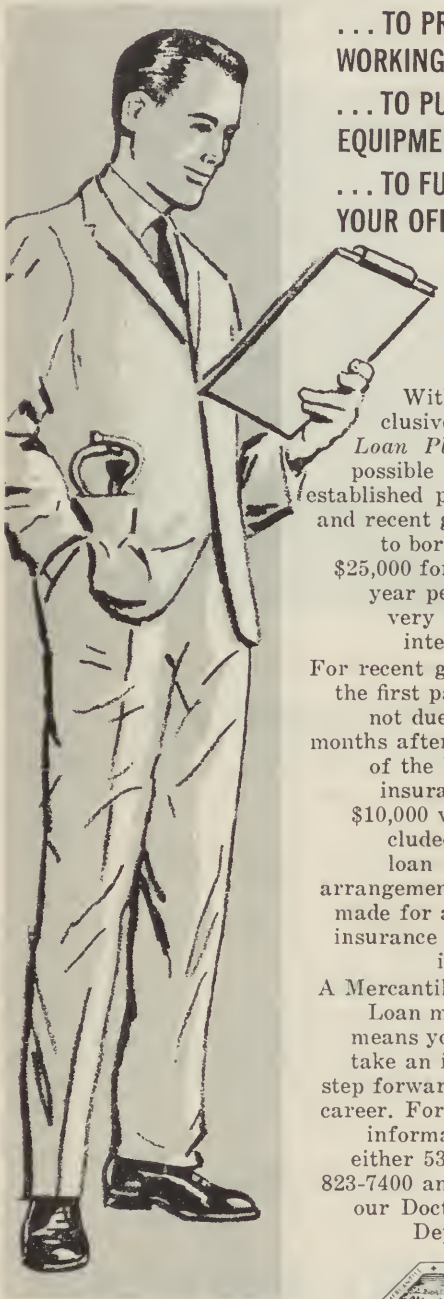
The Maryland Society of Anesthesiologists have selected the following to serve as officers: Joseph S. Redding, M.D., President; Gina M. Glick, M.D., Vice-President; Martin I. Gold, M.D., President-elect; Gerald J. Carroll, M.D., Secretary; and Albert Pats, M.D., Treasurer. Delegates to the ASA are Thomas D. Graff, M.D., and Lionel Glassman, M.D.

John Sargeant

Executive Secretary

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Urea Nitrogen Test (B.U.N.): a modified Berthelot procedure combining urease with a phenate and a hypochlorite indicator.

Uric Acid Test: is a modified Brown procedure and takes thirty seconds to perform.

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From Washington

The American Medical Association favors utilizing Medicaid instead of expanding Medicare. Charles Hudson, MD, AMA president, outlined the Association's position at a House Ways & Means Committee hearing on the administration's bill "Social Security Amendments of 1967" (H.R. 5710). He was accompanied by Milford O. Rouse, MD, AMA president-elect.

"Available tax funds should be used to give maximum health care to those who need help," Dr. Hudson said. "Expenditure of public funds on those who do not need help limits the resources available to those who do need it. . . .

"We believe that a properly administered Title 19 (Medicaid) with realistic criteria of eligibility designed for economically disadvantaged persons, plus the encouragement and improvement of voluntary health insurance and prepayment plans for the solvent, provide the best approach to health care financing."

Dr. Hudson said AMA representatives would be glad to meet with the Committee and other interested parties to hammer out a workable approach to solving the many complex problems in the Medicare program, particularly with respect to Part B.

"Unfortunately, Part B did not receive an amount of public or congressional debate warranted by the nature and scope of the proposal," he said. "This committee is now confronted with many problems inherent in the vast undertaking of the federal government in becoming directly involved in the total health care of almost 20 million persons.

"We believe it is possible for the Congress, the medical profession and others interested in the subject to develop a new mechanism for delivering medical care to people over 65 that would be more consistent with existing private sector mechanisms. . . ."

Dr. Hudson said that carriers, physicians, patients, and the government all are dissatisfied for various reasons with Part B. He said one possible solution might be to substitute for the Part B program a subsidy to all eligible persons for the purchase of private insurance.

Highlights of AMA testimony included:

Section 125, to include the disabled—The adoption of Section 125 . . . could change the direction of Medicare from a program for older persons to one aimed at various select categories . . . we urge the Committee to reject this provision.

Section 127, to include podiatry—While recognizing the usefulness of podiatry services, we are impelled to note that if the amendment is adopted, the podiatrist could assume responsibility for the care of some of the more difficult problems in medicine. We believe this to be unsound.

Section 130, to create a Part C of Title 18—This section would provide a new *Part C* to cover payment for hospital services rendered to hospital outpatients, and for diagnostic specialty services to both outpatients and inpatients of hospitals. The AMA opposes Part C *in toto*.

Section 131, to eliminate physician certification—The AMA endorses Section 131, which would remove the requirement of a physician's certification for inpatient hospital care for each Medicare patient admitted to a general hospital. We urge the Committee to consider this amendment favorably and remove an unnecessary impediment to the operation of Part A.

We further urge that the requirement for re-certification be similarly deleted, since this need should be satisfied as a result of the work of utilization review committees.

Until re-certification is deleted, we suggest that the first certification date be the 20th day of hospitalization, as permitted in the existing law.

Section 220, to limit income maximum under Title 19—The AMA supports the concept of limiting eligibility for Title 19 benefits to persons who genuinely need financial assistance in meeting their health care needs.

Section 226, to provide free choice under Title 19—Although free choice is guaranteed for Title 18 recipients, a similar privilege was not extended to Title 19 beneficiaries. We believe this was an oversight, and we heartily support this perfecting amendment to Title 19.

Additional Amendments Proposed by the AMA

First, the AMA recommends that Title 18 be amended to permit payment of charges for professional services on the basis of a physician's itemized statement of charges rather than a receipted bill. Second, we recommend that Title 18 be amended to remove the requirement for three days of hospitalization before qualifying for extended care benefits. In addition, we offer a recommendation relating

A monthly summary of Washington news prepared in the Washington, DC, office of the American Medical Association.

to psychiatric care under Title 18.

Regarding Title 19, we offer six amendments:

First, that the program permit payment to the patient for services rendered to him by a physician on the basis of the physician's itemized statement of charges.

Second, that the program clearly provide for the payment of physician fees on the basis of his usual and customary charges, using the same approach as that applied under Title 18.

Third, that Title 19 encourage the use of insurance carriers in the implementation of state programs.

Fourth, that in the implementation of Title 19 programs, there be no requirement for certification or re-certification.

Fifth, that Title 19 permit all state plans to vary the eligibility standards within a state to recognize the very real differences in the cost of living in a rural area, a small town, a city or a metropolitan area.

Our sixth recommendation relates to the fact that Title 19 benefits differ for mentally ill patients depending on whether they are above or below age 65. We believe there should be no distinction in the services available to mentally ill patients.

Physician Coverage Under Social Security

We believe that physicians, having been brought under Social Security coverage, should be accorded the same privilege and opportunity for reaching a fully insured status as was accorded other professional groups when they were included in the program.

Accordingly, we urge this Committee to consider the adoption for physicians of an "alternative insured status" similar to that permitted by the amendments of 1954 and 1956, which brought into the program many new groups of people and professional self-employed persons, including lawyers.

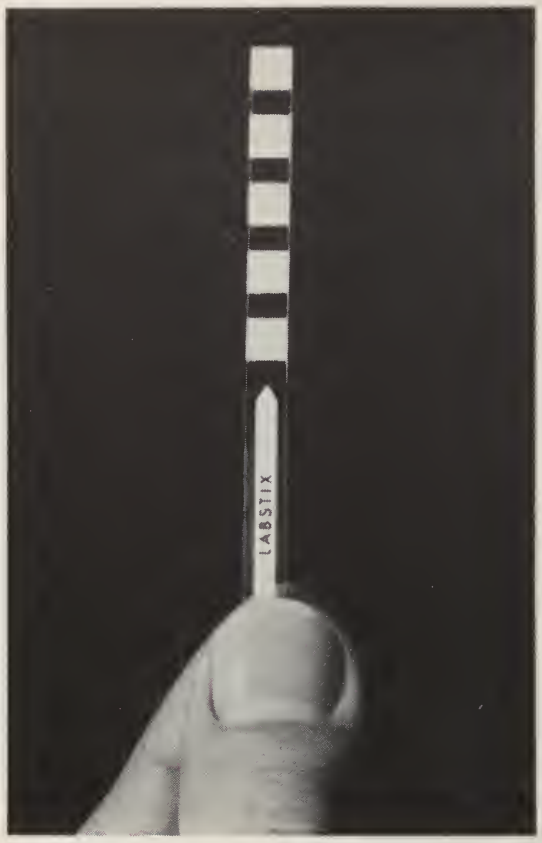
GEORGETOWN TO ESTABLISH RADIO LINK WITH MEDICAL SCHOOLS IN OTHER COUNTRIES

Medical schools and hospitals throughout the world now have a new communication link with the United States. The new facility is a shortwave radio station, WA3FXJ, with studios on the campus of Georgetown University, according to Patrick J. Doyle, MD, professor and chairman of the Department of Community Medicine and International Health in the University's School of Medicine.

Financial support of the station is a joint project of the medical school and of Riker Laboratories, Northridge, Cal, pharmaceutical manufacturer, a division of Rexall Drug and Chemical Company.

The new unit is called Georgetown's "International Medical Amateur Radio Station." As far as is known, it is the first ham radio station in the United States used primarily for the teaching of medical students in other countries.

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Riker, Dr. Doyle said, "Initially our purpose will be to provide a series of medical programs and an emergency consulting service for teaching purposes whenever and wherever the need exists. Also, this new unit will permit Georgetown physicians to consult with a number of prominent leaders in international health."

The radio station will be on the air in May, according to Sanford Vernick, MD, assistant professor in the Department of Biology at Georgetown, and a licensed amateur radio operator. Fifteen ham operators who are either faculty members or students will help operate the station.

Initial broadcasts will be between Georgetown and similar shortwave medical radio stations located at the University of Guayaquil Medical School in Guayaquil, Ecuador, and at medical missions in Latin America.

According to Drs. Doyle and Vernick, future radio contacts are planned between WA3FXJ and the Edinburgh School of Medicine in Scotland, and the radio station at the University of Mexico Medical School in Mexico City.

"Consultations between Georgetown and other 'stations' will also offer an exchange of information on medical techniques, drug information, nursing, medical administration, rehabilitation, and other areas of common interest," said Dr. Doyle.

From an April 1967 news release of Paul Klemtner & Co., Inc.

SENATOR TYDINGS PROPOSES CHANGES IN HEALTH CARE SYSTEM

Senator Joseph D. Tydings (D-Md) warns of "tremendous and terrible social and economic costs" inherent in this nation's system of health care and proposes a complete reorganization of the health care system. In a speech prepared for delivery at a banquet commemorating the 10th anniversary of the founding of Washington Hospital Center, the Senator said, "If our plan had been to create the most inefficient, most expensive system of health care possible, then we would have created a system very much like the one we have now."

It was read by Stephen J. Pollak, Presidential adviser for National Capitol Affairs. Senator Tydings was ill and unable to attend.

Noting that the system of health care now suffers from serious imbalances, he said the major



emphasis in health care is on the care of critically ill patients in hospitals—"this is the most expensive option available in the system, whether the costs are measured as economic costs or as social costs." The result of the emphasis on hospital care for critically ill patients is the neglect of prevention of disease and, where that fails, of early detection and treatment, Senator Tydings said.

"Our system can invent an artificial kidney and develop surgical techniques for transplanting living kidneys, but it cannot quite find the time to diagnose and treat high blood pressure before the kidneys are destroyed," he said.

"Our system is capable of great, even heroic efforts to save citizens at the brink of death, but it is often unable to serve the citizens before they have reached that brink."

Senator Tydings proposed new priorities for the health care system. The first priority, he said, should be the prevention of disease and the second major emphasis must be early diagnosis and treatment. The care of critically ill patients in hospitals should be the option of last resort in any system responsive to the needs of the citizens, he said. This would reverse the present priorities in health care, Senator Tydings said.

A second major proposals would be a reorganization of hospitals to make them genuine medical centers, providing comprehensive care rather than simply intensive care.

"Emergency rooms and outpatient clinics can no longer be administrative orphans hidden away in hospital basements," he said. These services, along with programs for long-term care, convalescent care and even home care, must be integral parts of the hospital system, he said.

Senator Tydings said the reforms must be made because the system of health care now faces collapse beneath the weight of its social and economic costs.

From Baltimore

PHYSICIAN REFERRALS INVITED IN COOPERATIVE STUDIES

The Medical Service of the US Public Health Service Hospital in Baltimore is actively participating in two cooperative research projects studying the influence of drugs on the morbidity and mortality in patients with mild or moderate hyper-



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1. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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tension and patients with coronary artery disease.

Physician referrals of selected patients to the Cooperative Study on the Treatment of Hypertension or to the Cooperative Coronary Heart Disease Drug Project would be welcomed. Both of these studies are National Heart Institute sponsored projects, and the Coronary Drug Project is approved by the American Heart Association. Patients referred for either study can be followed concurrently with the referring physician or will be followed completely by our hospital, contingent upon the discretion and desires of the referring physician and patient. A full and informed consent is obtained from each patient prior to his or her entry into the study, and patients' health and well-being are of major concern.

In his announcement of these studies, Nicholas P. Sinaly, MD, chief of Medical Service, US Public Health Service Hospital, described the Cooperative Study on the Treatment of Hypertension as "a double-blind study of males and females with mild to moderate hypertension (Diastolic BP 90-115 mm Hg), aged 21 to 55 years, over a seven-to-ten-year period." Dr. Sinaly's announcement also provided the following pertinent information:

1. *Excludable conditions for the study*—diabetes mellitus, cardiomegaly, arteriosclerotic heart disease or peripheral vascular disease, congestive heart failure, abnormal ECG, valvular heart disease, significant renal disease.
2. *Treatment*—rauwolfia-chlorothiazide combination, or placebo.
3. *Referrals*—call Mrs. Prout at the US Public Health Service Hospital, BE 5-3930, Ext 254/255/235.

The Cooperative Coronary Heart Disease Drug Project is described as "a five-year double-blind study comparing the effects of nicotinic acid, d thyroxine, clofibrate, conjugated estrogens, or placebo, on morbidity-mortality in males aged 30 to 64 with docomented myocardial infarction in the past." Excludable conditions for this study include the need for long-term anticoagulant therapy, diabetes requiring insulin, Class III or IV cardiac disease. Referrals can be made by calling: US Public Health Service Hospital, BE 5-3930, Ext 435.

(*Continued*)

Events at



J. Morris Reese, MD, president (1966-1967) of the Medical and Chirurgical Faculty, presented the AMERF checks at the banquet held at the Sheraton-Belvedere Hotel during the 169th Annual Meeting. Thomas B. Turner, MD, dean of The Johns Hopkins University School of Medicine, is seen receiving check for over $9,500.



William S. Stone, MD, dean of the University of Maryland School of Medicine, receiving from J. Morris Reese, M.D., an AMERF check for over $15,000.



Warfield M. Firor, MD, and Mrs. Firor receiving the "Community Service Award" from J. Morris Reese, MD.



Robert vL. Campbell, MD, receiving the Past President's Plaque from outgoing president J. Morris Reese, MD.



Andre Fesus, MD, presenting J. Morris Reese, MD, with a citation for the Medical and Chirurgical Faculty by the Hungarian Freedom Fighters Association.



James W. Barnes, Jr., MD, of Glenn Dale, Md. receiving from James B. Brooks MD, chairman of the Committee on Program & Arrangements, the Aesculapius Award presented by Mead Johnson Laboratories.

169th Annual Meeting



George L. McLean, MD, and Theodore H. Morrison, MD, both 50-Year Members of the Medical and Chirurgical Faculty, were honored by J. Morris Reese, MD, at the House of Delegates meeting.



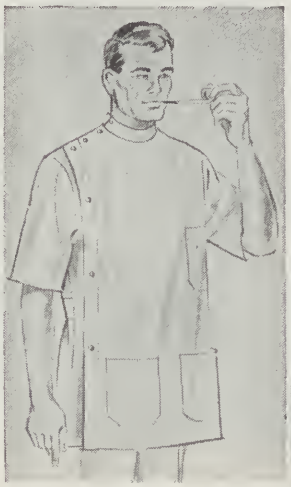
Richard D. Bauer, MD, receiving the Presidential Gavel from J. Morris Reese, MD, outgoing president of the Medical and Chirurgical Faculty, at the House of Delegates meeting in the Faculty Building.

(Medical News *continued on page* 28)

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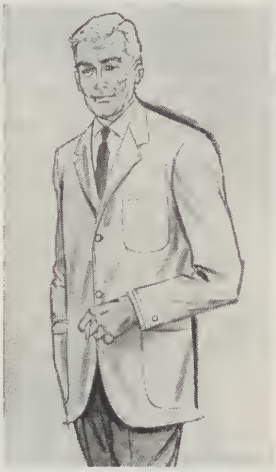
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GENERAL PRACTICE SCHOLARSHIPS

The first recommendation of the Governor's Commission to study the need of physicians in the State of Maryland is presently being implemented at the University of Maryland School of Medicine, where a new scholarship program, created by the 1965 Session of the Maryland General Assembly, went into effect this past fall. The ten scholarships, which provide an annual stipend of $1500, are awarded at the rate of ten a year by the State Scholarship Board. The successful candidates for 1967-1968 are:

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Richard Alan Bloomfield
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Glen Burnie, Md

James Stephen Murphy
Lexington Park, Md

David Browne Posner
Caveswood Lane
Owings Mills, Md

Wm. David Hakkarinen
910 Somerset Place
Hyattsville, Md

John Franklin Kressler
111 Fourth Ave, SE
Glen Burnie, Md

Stephen N. Levin
8810 Stephanie Road
Randallstown, Md

George Charles Samaras
228 Bay Bridge Road
Annapolis, Md

Michael Alan Silverman
814 Malibu Drive
Silver Springs, Md

John Wesley Wilson
1251 Vogt Avenue
Baltimore, Md

The scholarships are granted only to those students who have been admitted to the University of Maryland School of Medicine. Each candidate must have been a resident of Maryland for at least five years preceding the date of the award and must have received a bachelor's degree from an accredited institution.

Prior to the final awards, which are based on academic ability, aptitude and financial need, each recipient must give bond to the State of Maryland

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affirming that he will engage himself to serve as a general practitioner of medicine for three years in an area of need in this State. The area of need is to be determined by the State Department of Health in consultation with the Medical and Chirurgical Faculty of Maryland.

The Congress of Delegates of the American Academy of General Practice in October has created a student affiliate membership that provides these medical students with their first opportunity to be affiliated with an organization of practicing physicians. The President of the Maryland Academy of General Practice wrote each one of the scholarship recipients a personal letter inviting him to join the Maryland Academy of General Practice. *From the News Bulletin of MAGP and DCAGP, Spring 1967*

From Chevy Chase

Grants for eight projects to demonstrate or investigate new systems for disposing of solid wastes without endangering human health or contaminating the environment have been announced today by the Public Health Service's National Center for Urban and Industrial Health. The grants, awarded under the Center's Solid Wastes Program, total nearly $568,000.

The eight awards bring to 26 the number of demonstration or investigation projects now being conducted by local and state agencies with financial support from the Public Health Service. More than $3,110,000 has been committed for the 26 projects.

"Much of the success of the Solid Wastes Program depends on the development by local and state agencies of projects for new and improved approaches to solid wastes management which can qualify for two-thirds Federal support under the Solid Waste Disposal Act," said Leo Weaver, the Solid Wastes Program Chief. "Disposal practices in the United States are generally backward and insanitary partly because local and state governments have lacked funds to risk on advanced techniques and equipment. But this barrier to progress has been substantially removed by the availability of federal aid for bold and innovative demonstration projects. Communities and states now have the chance to try new approaches that could lead to great improvement in solid waste

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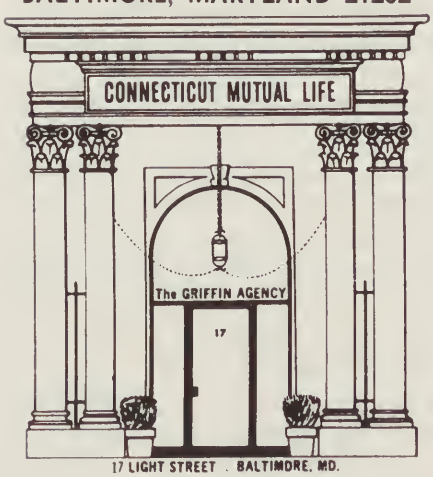
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disposal practices."

In addition to aiding demonstration and investigation projects, the Solid Wastes Program supports research and training, helps finance solid wastes planning by states, and provides technical assistance to local and state governments.

Several of the new projects are to merge individual community disposal operations into area-wide systems with improved health protection and efficiency. Others are to demonstrate advanced incineration with negligible air pollution. One project is to illustrate the feasibility of building an amphitheater and coasting ramp from solid waste sanitary landfills. Still another is to show that solid wastes can be used to reclaim and beautify abandoned strip mines.

Included among the eight grantees is the Maryland State Department of Health, which has been awarded $28,597 to demonstrate abandoned strip mine reclamation by conversion to sanitary landfills. The project director is Wilfred H. Shields, Jr., acting chief of the Department's Division of Solid Wastes.

From a US Public Health Service news release, April 1967.

From New York

The full dimensions of the nursing shortage in the United States were revealed today with the issuance of *Data,* a fact sheet on the nursing situation prepared by the National League for Nursing, New York.

The fact sheet states that there are 621,000 professional nurses employed today while the need is for 746,000—a shortage of 125,000. Prepared as background for the League's eighth biennial convention held May 8 to 12 at the New York Hilton Hotel, it was made public by Inez Haynes, RN, general director of the League.

"Authorities set the goal for 1970 at 850,000 to 1,000,000 active RNs," says the summary. "The bare facts show that the shortage can reach some 344,000—more than one-third the total need—in three years. This means thousands of budgeted staff vacancies in hospitals and other agencies, insufficient and improperly prepared faculty in many nursing education programs, and inadequate nursing for the American public."

A shortage of licensed practical nurses also

exists. The total number now employed is placed at 282,000, while the need is for 311,000.

"Actually," Miss Haynes explained, "the number of practicing registered nurses (RNs) has increased tremendously in the last ten years—from 430,000 to 621,000. I know no other profession that has grown more rapidly. But events have outstripped the growth. Not only have the population explosion, the growth of health insurance, and the advent of Medicare and Medicaid increased the demand for nurses, but more highly specialized knowledge is required of the modern nurse. Nursing responsibilities have increased proportionately to the increase in medical knowledge and techniques."

The "quality factor" is an important consideration in the supply and demand picture, she added. Physicians rely increasingly on professional nurses to help bring new surgical techniques, chemotherapy treatments, and rehabilitation methods to patients. This, in turn, means that a larger number of nurses with college degrees are needed for expert patient care, for supervisory posts in hospitals and clinics, and for teaching and administration.

The National League for Nursing, with 24,000 individual and 1,800 agency members, such as hospitals, nursing schools, public health agencies, and voluntary health associations, conducts programs across the country to encourage community action for the improvement of nursing services and nursing education. It accredits schools of professional and practical nursing and public health nursing agencies and provides testing services for evaluating the potential of pre-nursing students and the educational achievements of nurses and nursing students. Licensure tests for professional and practical nurses in the United States and Canada are prepared, distributed, and scored by the League.

HARTFORD FOUNDATION REPORTS $14,462,862 IN 1966 MEDICAL RESEARCH GRANTS

New pathways to the prevention, diagnosis and cure or palliation of many human afflictions were opened last year by medical investigations supported by The John A. Hartford Foundation, Inc., Ralph W. Burger, the Foundation's President declared in its 1966 annual report just issued.

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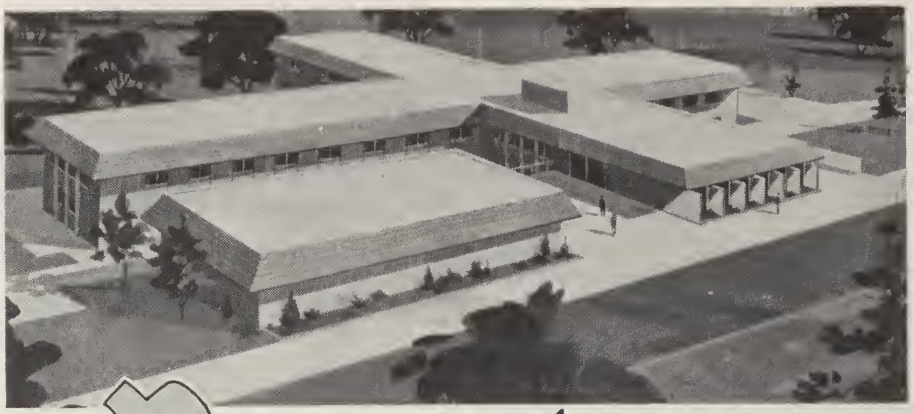
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funds for medical research, The John A. Hartford Foundation appropriated in 1966 a total of $14,462,862 for 82 new and continuing programs. This brought to 232 the active research and clinical projects it was funding through grants to 136 hospitals, medical schools and other research facilities in 69 communities in the United States and Canada, according to the report.

The projects, Mr. Burger stated, are almost as varied as medicine itself and employ the talents of virtually every known discipline relating to the health sciences.

"While no one field is more vital than another," he said, "We are especially pleased at having played a part in such pioneering research ventures as cryosurgery, hemodialysis for chronic uremia, medical applications of the laser, and the intensive-care concept now being widely used to save lives of both infants and adults."

Mr. Burger pointed out, however, that the basic causes of a large number of bodily dysfunctions are yet unidentified and, therefore, therapy is lacking or ineffectual. It is with this in mind, he added, that the Hartford Foundation continues its encouragement of medical research and, particularly, of investigations aimed at bringing laboratory-developed findings into clinical application.

From Chicago

"AMA JOURNAL" ESTABLISHES MEDICINE-RELIGION DEPARTMENT

Physicians have long been troubled by the knowledge that playing the role of healer sometimes requires them to "play God," too.

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Sometimes the operation fails, but in a number of cases, it succeeds; more than 500 people are alive today with transplanted kidneys.

Regardless of whether the sick boy recovers, however, the physician is haunted by one thought: suppose something goes wrong with the healthy twin's remaining kidney. A person can live a normal life with one



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Recently Modell[2] has stated: "The mercurial diuretics are the injectable diuretics of choice since they are the most potent as well as the most dependable. Their toxicity is not an important consideration either by comparison with other potent diuretics or in relation to the seriousness of the conditions in which they provide such excellent relief."

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IN BRIEF

Mercuhydrin is indicated in edema of cardiac or hepatic origin and in the nephrotic syndrome; it is contraindicated in acute nephritis and in anuric or oliguric states. *The usual adult dose is one to two cc. daily or every other day until "dry weight" is obtained.* Sensitivity is rare but small initial doses are advised to minimize potential reactions; vertigo, fever, and rash have occurred. Overdosage may produce electrolyte depletion, muscle cramps, and G.I. reactions. Supplied: 1 cc. and 2 cc. ampuls in boxes of 12, 25 and 100; 10 cc. rubber capped, multiple-dose vials (intramuscular or subcutaneous use only) in boxes of 6 and 100.

1. Gold, Harry, *et al.: A System for the Routine Treatment of the Failing Heart,* The American Journal of Medicine, Vol. III, No. 6:665-692 (Dec.) 1956.

2. Modell, Walter: *Drugs of Choice 1966-1967,* p. 97, 1966.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

kidney—that is what supports the theory of transplantation from live donors—but one cannot live without any kidneys. Disease could cut down the boy at any time.

By deliberately removing a healthy, functioning part of the boy's body, has the physician consigned him to possible future death?

Or are the parents responsible? They gave permission for the operations. Was the physician merely a technician, carrying out their orders?

And what of the healthy boy? He is a minor. Does he have any rights in the matter? Could there be a case in which parents used unusual coercion on such a child to save the life of another?

These are some of the questions that trouble medical men of conscience on transplantation. Other areas of medicine present similar questions of ethics and morality.

This is why *JAMA*, the Journal of the American Medical Association, has begun a new section, "Medicine and Religion," designed to discuss these issues. The first question-and-answer section (on transplantation) appeared in the April 10 issue.

Here is part of what Joseph E. Murray, MD, a Boston surgeon, had to say about the problem of the 10-year-old twins:

"Organ transplants, as a therapeutic maneuver to prolong life, are certainly justified as far as the recipient is concerned. The source of the kidney, however, provides a major moral, legal, and ethical problem. If the source is a recently deceased individual whose nearest relatives have voluntarily donated the kidney, there is no problem. If the source is an elective (kidney removal) for the benefit of another human being, and a kidney is used which would otherwise be discarded, again, there is no problem. However, when the donor is a living healthy volunteer, either a member or a nonmember of the family, a definite problem arises. Here we are embarking on a major surgical operation with a slight, but definite, risk from anesthesia, operation, or postoperative complications.

"This procedure is not for the benefit of the person being operated on, but for someone else. All previous medical and surgical training has been geared to weighing the advantages and disadvantages in any one patient of a proposed therapeutic measure. In this instance, however, for the donor a physiological deficit will always occur, and no possible good can accrue to him physically."

Dr. Murray pointed out, however, that the kidney donor may derive "a certain spiritual benefit" from the donation, which is "probably the purest form of charity next to the giving of one's life. For a truly unpressured volunteer, this spiritual satisfaction can more than compensate for the physical trial of a nephrectomy."

The courts in various states have recognized the validity of a kidney donation by a minor child "on the principle that the child would be harmed psychologically, spiritually, and aesthetically if he were deprived of the opportunity of donating a kidney to save his identical twin," Dr. Murray said.

The question concerning the twins' kidney exchange came from a Louisiana physician, who requested the opinion of a priest because the family is Catholic.

Said the Rev. John J. Lynch, of Weston, Mass: "It should first be noted that on the question of organic transplantation inter vivos (from one living person to another), the Roman Catholic church has never yet declared an official teaching."

Private theologians, however, have been discussing the problem ever since transplantation became a medical practicality, Father Lynch said.

"Those who challenge the permissibility of this form of organic transplantation do so because of a sincere conviction that only when it is necessary for one's own total medical good may one sacrifice a bodily member," he said. "In substantiation of this premise they are able to cite several papal statements which seem to concur with their position. And since the donor in a transplant transaction has physically only loss to show for his pains, this school of thought concludes—most logically, if their premise be granted—to a prohibition against the procedure.

"Those who defend the . . . procedure deny the . . . principle which would allow bodily mutilation only for the total good of the patient himself. They maintain that the law of fraternal love—whereby one may do for another whatever one may legitimately do for self—can also be invoked in justification of certain organic transplants. Their reasons, though weighty, are not altogether conclusive theologically; but neither are the contrary arguments submitted by the opposition," Father Lynch said.

Where does this theological deadlock leave the conscientious physician—in this case, the Roman Catholic physician?

"On the supposition that proper consent is obtained, it leaves him entirely free to follow in practice, if he so chooses, the opinion which grants him the greater liberty of medical action," Father Lynch said. "No theologian could legitimately accuse of moral wrongdoing the physician who involves himself professionally in organic transplantation with due regard for those precau-



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tions which sound medical sense would prescribe for that procedure.

"Or, to put it more positively, the doctor, who in medical prudence seeks to preserve human life by means of organic transplantation can merit no less theologically than he does scientifically," Father Lynch said.

In coming weeks, the Medicine and Religion section of *JAMA* will discuss such topics as the relationship of psychiatry and religious counseling in caring for the hospitalized patient, and the role of physicians and clergymen in maintaining the patient's privacy while giving him maximum care. Physicians and clergymen of various religious faiths will discuss these questions.

The AMA's Board of Trustees established a Committee on Medicine and Religion in 1963. Under the direction of the Rev. Paul B. McCleave, subcommittees have been set up in medical societies in every state.

"The primary purpose was to create a climate in which doctors and their clergymen colleagues—ministers, priests, and rabbis—could work together most effectively," a *JAMA* editorial said. "At the bedside and in conferences, they are trying seriously to explore their mutual role in treating the whole man as they deal with his physical, mental, and emotional disorders. Scores of dialogues among physicians and between physicians and the clergy are taking place."

"Hopefully, physicians engaged in all of the many facets of American medicine will be stimulated to send in questions pertaining to this fascinating field," said Paul S. Rhoads, MD, chairman of the AMA Committee on Medicine and Religion.

Physicians' queries should be based upon specific clinical situations or social problems, and details should be limited to nine or ten sentences. Queries should be sent to Alfred Soffer, MD, 535 N Dearborn St, Chicago, Ill 60610.

From an AMA news release, April 1967.

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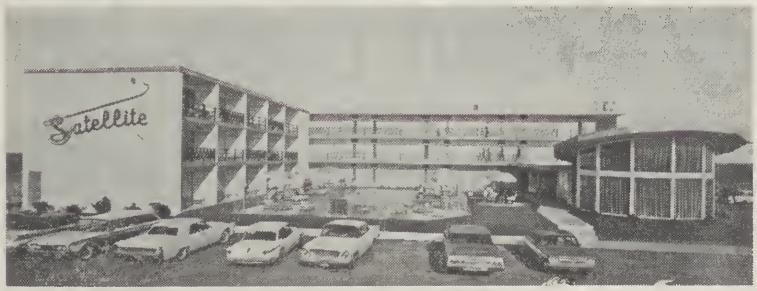
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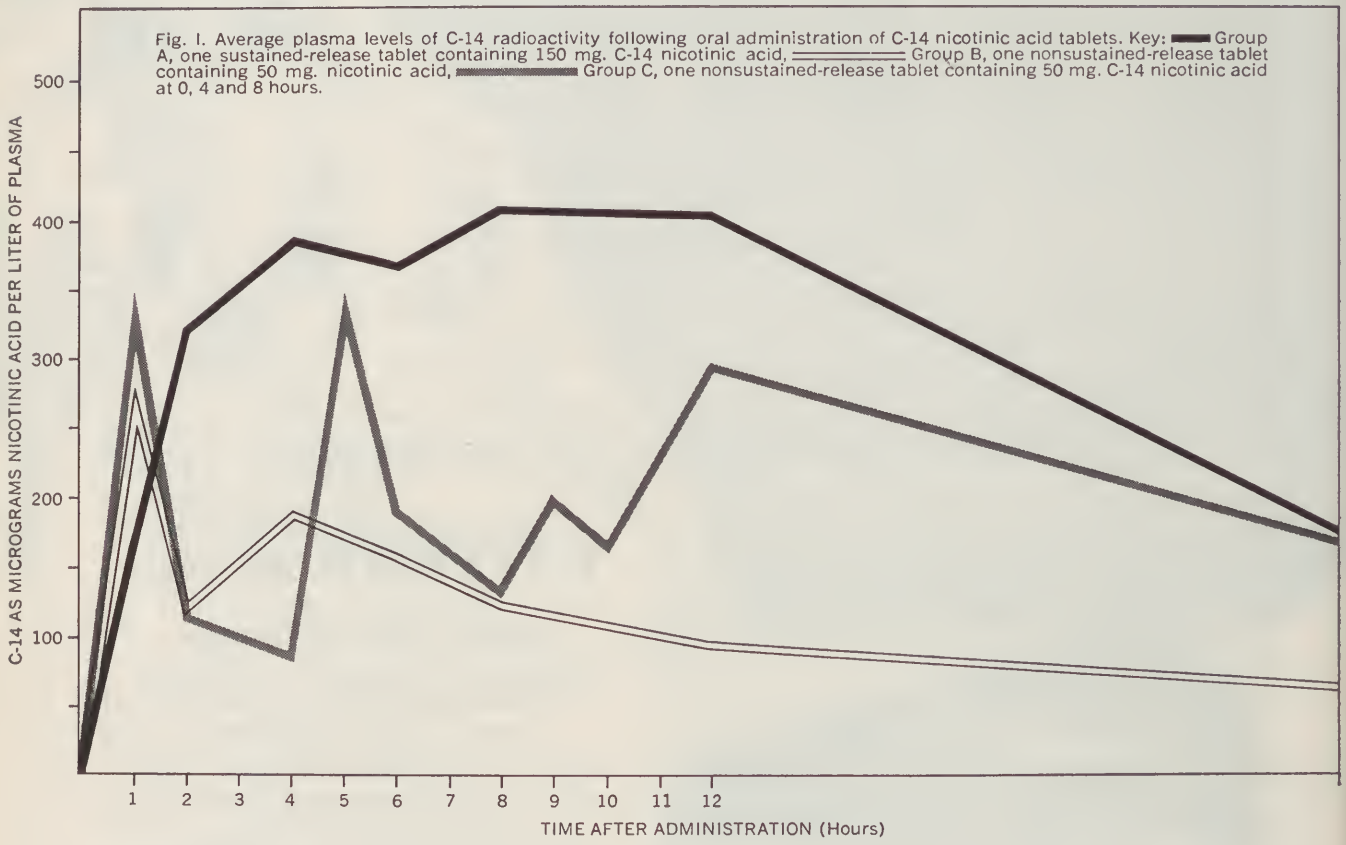
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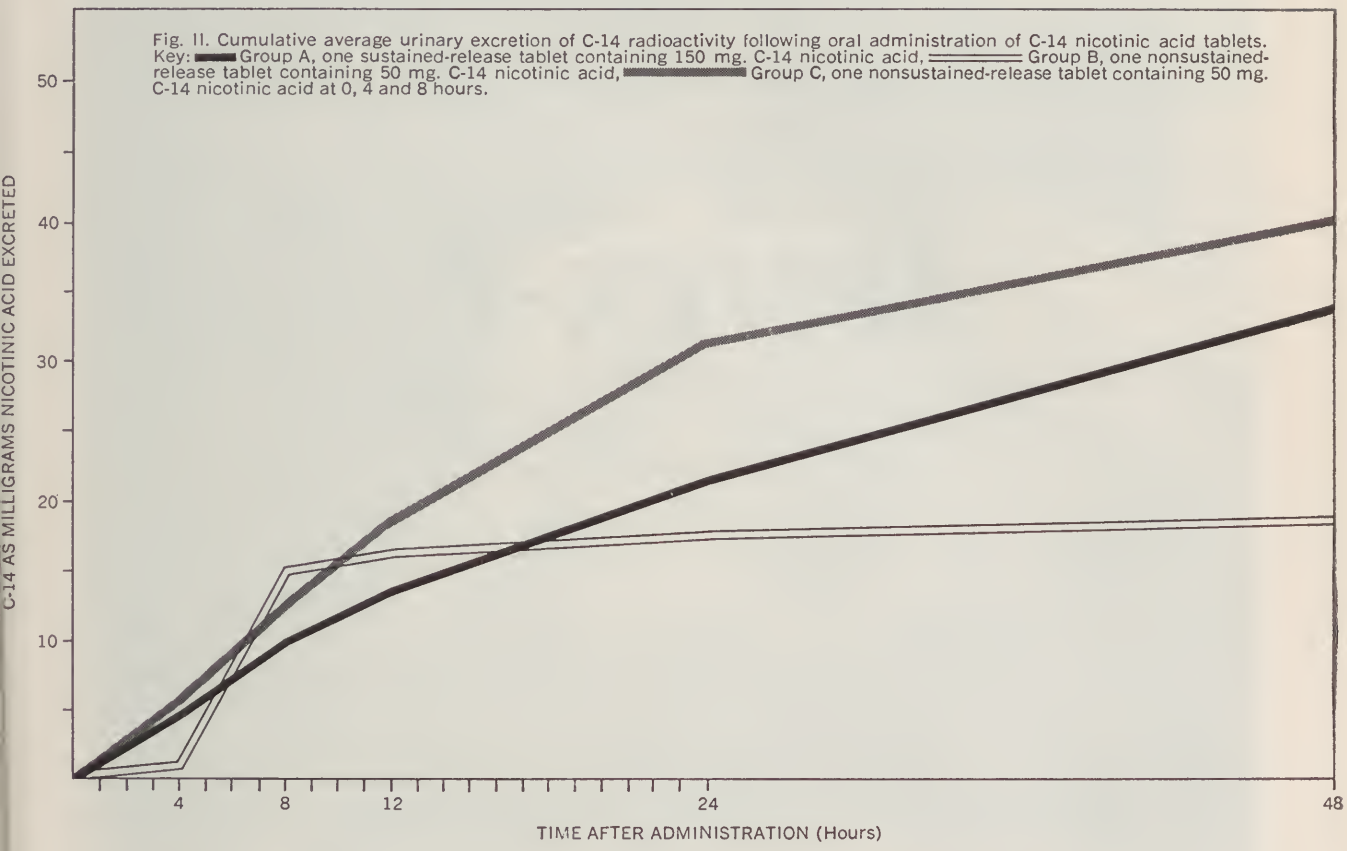
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References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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References: 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rawls, W., et al.: Med. Times, 87:818, 1959.

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BUSINESS SESSIONS

ANNUAL MEETING
April 19, 1967

MINUTES

The 256th meeting, first of the 169th Annual Session of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland, was held at The Alcazar, Baltimore, Maryland, at 9:40 AM, Wednesday, April 19, 1967, the President and Secretary being present.

The following delegates (or alternates) were registered as being in attendance; an asterisk indicates an alternate delegate:

Doctors: Manning W. Alden, Council; Robert G. Angle, Montgomery County; Timothy D. Baker, Baltimore City; John G. Ball, Montgomery County; Edward M. Barczak, Baltimore City; Richard D. Bauer, Council; Paul F. Guerin, MD, Baltimore City; Harry McB. Beck, Baltimore City; M. McKendree Boyer Past-President; Henry A. Briele, Council; Wendell J. Burkett, Kent County; Robert vanL. Campbell, Council; Douglas G. Carroll, Baltimore City; *Katherine A. Chapman, Montgomery County; H. Douglas Cooper, Wicomico County; Ernest I. Cornbrooks, Jr., Baltimore City; *Kenneth Cruze, Montgomery County; William B. Culwell, Carroll County; Worth B. Daniels, Baltimore City; Henry V. Davis, Cecil County; Melvin B. Davis, Baltimore County; John D. DeHoff, Baltimore City; DeWitt E. DeLawter, Montgomery County; J. Sheldon Eastland, Council; William Carl Ebeling, Council; Emanuel S. Ellison, Baltimore City; Robert W. Farr, Council; Vincent J. Fiocco, Jr., Carroll County; Whitmer B. Firor, Past-President; Russell S. Fisher, Council; Harold H. Gist, Washington County; William B. Hagan, Council; Louis E. Harmon, Baltimore City; John S. Haught, Prince George's County; William G. Helfrich, Baltimore City; Thomas F. Herbert, Howard County; Philip W. Heuman, Harford County; James P. Jarboe, St. Mary's County; Frederick M. Johnson, Charles County; Ferd E. Kadan, Baltimore City; James R. Karns, Baltimore City; Fayne A. Kayser, Council; Lauriston L. Keown, Baltimore City; Robert C. Kimberly, Council; Howard F. Kinnamon, Past-President; Louis Krause, Council; *John I. F. Knud-Hansen, Talbot County; Edward L. J. Krieg, Baltimore County; Henry P. Laughlin, Council; C. Rodney Layton, Queen Anne's County; Herbert H. Leighton, Garrett County; Charles H. Ligon, Montgomery County; *James McCarter, Dorchester County; William J. Mclafferty, Baltimore City; George S. Malouf, Prince George's County; Karl F. Mech, Council; B. Martin Middleton, Council; John E. Miller, Baltimore City; Donald W. Mintzer, Baltimore City; Frank K. Morris, Board of Medical Examiners; G. Allen Moulton, Jr., Allegany County; Frederick E. Musser, Prince George's County; Clayton Norton, Anne Arundel County; Richard Norment, III, Council; Charles F. O'Donnell, Council; Hilary T. O'Herlihy, Anne Arundel County; William A. Pillsbury, Council; *Carolyn S. Pincock, Montgomery County; Harold B. Plummer, Caroline County; Frank E. Poole, Wicomico County; J. Emmett Queen, Council; C. G. Rawley, Somerset County; Belden R. Reap, Montgomery County; J. Morris Reese, Council; Guy M. Reeser, Talbot County; Thomas Reid, Frederick County; Paul F. Richardson, Baltimore City; *James A. Roberts, Montgomery County; Raymond C. V. Robinson, Baltimore City; Donald J. Roop, Council; Salvador Rossello, Baltimore City; *Peter Santucci, Montgomery County; John F. Schaefer, Council; Emmanuel Schimunek, Baltimore City; Simons, Allegany County; Thaddeus C. Siwinski, Baltimore County; R. Kennedy Skipton, Prince George's County; Omar D. Sprecher, Jr., Washington County; Martin E. Strobel, Baltimore County; E. L. Suarez-Murias, Baltimore City; Thomas E. Van Metre, Jr., Baltimore City; Merton T. Waite, Anne Arundel County; Emerson C. Walden, Baltimore City; Hugh W. Ward, Calvert County; William H. F. Warthen, Past-President; J. Arthur Weinberg, Council; William C. Weintraub, Prince George's County; Lawrence R. Wharton, Jr., Baltimore City; Daniel Wilfson, Jr., Baltimore City; Charles H. Williams, Baltimore County; Eldridge H. Wolff, Council; Donald O. Wood, Baltimore County; Charles E. Wright, Frederick County; John D. Young, Jr., Baltimore City; Raymond M. Yow, Council.

Present also for the meeting were staff personnel.

The president made several announcements concerning the transaction of business at the meeting and for the information of the delegates.

MINUTES

The minutes of the September 9, 1966, session having been approved by the Executive Committee and having been distributed to all delegates were presented to the House for information.

GUEST INTRODUCED

Richard E. Flood, MD, President of the West Virginia Medical Scoeity, was introduced to the House.

NECROLOGY

After the Secretary read the following names of deceased menbers, the House of Delegates members rose in observance of a moment's silence in respect for their deceased colleagues:

Anne Arundel County

Johnson, Theodore H.	June 24, 1966

Baltimore City

Baggot, Bartus T.	June 13, 1966
Beck, Nathaniel M.	September 1, 1966
Bowditch, Sarah H.	July 21, 1966
Flippin, Eugene L.	March 17, 1967
Friedenwald, Edgar B.	May 22, 1966
Goldbach, Leo J.	May 20, 1966

Greenberg, Sahler M.	December 27, 1966
Grempler, Walter E.	July 28, 1966
Guttmacher, Manfred S.	November 7, 1966
Hart, J. A.	March 26, 1967
Highstein, Gustav	June 13, 1966
Katz, Albert H.	January 24, 1967
Mayer, Erwin E.	March 3, 1967
McKenzie, W. Raymond	June 26, 1966
Milan, Edward F.	March 1, 1967
Pair, James Mansfield	July 16, 1966
Peck, John L.	January 24, 1967
Schwartz, Daniel J.	April 15, 1967
Sherry, Milton	Nivember 1, 1966
Stifler, William C., Jr.	August 5, 1966
Thomas, Henry M.	June 28, 1966
Wilder, Earle Maurice	June 3, 1966

Baltimore County

Benson, Edward H.	March 22, 1967
Dalmau, Louis Z.	July 4, 1966
Dunton, William R.	December 23, 1966
Hammett, Walter M.	November 6, 1966
Riley, Robert H.	January 25, 1967

Cecil County

Morrison, Winfred T.	September 2, 1966

Dorchester County

Hanks, William H.	August 10, 1966

Frederick County

Lansdale, P. S.	December 31, 1966
Slusher, Hamilton J.	December 12, 1965

Harford County

Garey, James Lyman	June 25, 1966

Prince George's County

Boyd, James Irving	July 31, 1966
Christensen, Thomas A.	May 4, 1966
Clum, John P.	October 4, 1966
Seron, Vaheh M.	October 7, 1966
Trozzo, Frank M., Jr.	October 20, 1966

Queen Anne's Count

Hoyt, Irvin G.	March 31, 1967

Somerset County

Johnson, Robert H.	March 9, 1967

Talbot County

Palmer, W. N.	December 23, 1966
Reeser, Guy M., Sr.	January 22, 1967

Washington County

Bell, Royal A.	February 24, 1967
Bowen, Mary E.	February 6, 1967
Shealy, Walter H.	April 15, 1966
Shupp, F. F.	December 27, 1966

Affiliate

Lachman, Harry	December 1, 1966
Harrat, Frank T.	March 19, 1967

TREASURER'S REPORT

The Treasurer then presented his report for the year 1966, which had been distributed. The Auditor's report was approved by unanimous consent.

TREASURER'S SUPPLEMENTAL REPORT

The Teasurer then presented a supplemental report outlining the receipt by the Faculty as remainderman of funds from the Walter R. Steiner Estate; as well as an additional contribution to the Hundley Memorial Lecture Fund from Mrs. J. Mason Hundley, Jr.

EMERITUS MEMBERSHIP

On motion of the Chairman of the Council, the following members who had received the recommendation of the Council, were elected to Emeritus Membership:

Prince George's County—H. Wayne Glickfield, MD

Washington County—Philip J. Hirshman, MD

REGIONAL MEDICAL PROGRAM FOR HEART DISEASE, CANCER AND STROKE

Thomas B. Turner, MD, Dean of The Johns Hopkins Medical School and newly-appointed coordinator of the Regional Medical Program for Heart Disease, Cancer and Stroke, was introduced to the House and spoke briefly on the concepts involved in the program and its formation and operation in the near future.

EDUCATIONAL FUND APPROPRIATION

Dr. Heldrich was by unanimous consent granted leave to present the report of the Committee on Postgraduate Education, Preventive Medicine and Public Health in the absence of its chairman. On behalf of the Chairman, the following motion was adopted unanimously:

Resolved, That the sum of $15,600 be allocated from the Educational Fund of the Faculty for the continuation of the Medic Network for the period from July 1967 to July 1968.

NOMINATING COMMITTEE REPORT

Dr. Campbell, Nominating Committee Chairman, presented the following slate:

President-elect
- Arthur G. Siwinski, Baltimore (President-elect 1967-68; President 1968-69)

First Vice-president
- Henry A. Briele, Salisbury

Second Vice-president
- Wolcott, L. Etienne, College Park

Third Vice-president
- George O. Eaton, Baltimore

Secretary
- William A. Pillsbury, Timonium

Treasurer
- Karl F. Mech, Baltimore

Councilors
- John M. Dennis, Baltimore, Central District (1971)
- Harry M. Robinson, Jr. Baltimore, Central District (1971)
- Donald J. Roop, Baltimore, Central District (1971)
- Raymond M. Yow, Salisbury, Eastern District (1971)
- J. Parran Jarboe, La Plata, Southern District (1971)

Delegate to American Medical Association
- J. Sheldon Eastland, Baltimore (Jan. 1, 1968-Dec. 31, 1970)

Alternate Delegate to American Medical Association
- Robert C. Kimberly, Baltimore (Jan. 1, 1968-Dec. 31, 1970)

Committee on Program and Arrangements
- John B. De Hoff, Baltimore (1972)

Library and History Committee
- Robert B. Goldstein, Baltimore (1973)

Finney Fund Committee
- Richard W. TeLinde, Baltimore (1973)

Board of Medical Examiners
John H. Hornbaker, Hagerstown (June 1967-June 1971)
Frank K. Morris, Baltimore (June 1967-June 1971)

The floor was opened to further nominations for these offices and there being none, nominations were closed by general consent. The election is to be held at the second meeting of the session, Friday, April 21, 1967, at the Faculty Building. The nominees for the Board of Medical Examiners are to be elected at the General Session, Thursday, 12:15 PM, April 20, 1967, at The Alcazar.

PRESIDENT-ELECT OF AMA

Milford O. Rouse, MD, President-elect of the AMA, was introduced to the House and presented greetings from the American Medical Association.

FIFTY-YEAR PIN PRESENTATION

The President, on behalf of the Faculty, then presented Fifty-Year pins to these members who were able to be present at this session:
Theodore H. Morrison, MD
George McLean, MD

BYLAWS COMMITTEE REPORT

Dr. O'Donnell, Bylaws Committee Chairman, on its behalf, moved the adoption of the following Bylaw amendments which, after debate, were adopted in each case by more than the required two-thirds vote:

Amend Article I, Section 1, by adding: "Membership in a component society shall carry with it membership in the appropriate class of membership in the Faculty."

Amend Article II, Section 4, by striking out the word "active" before the word "members."

Amend Article III, Section 4, by striking out the second sentence and inserting: "Any member whose dues are unpaid by March 1 each year shall be deemed to be not in good standing and shall forfeit all rights in the Faculty and its components, and shall not be reinstated until after the Annual Meeting and all arrearages are paid. If the member's dues are not paid up by December 31 of that year he shall be dropped from the roll of members."

Amend Article VII, Section 2, Clause 9, by substituting for it the following: "Appoint an Editor of the *Maryland State Medical Journal* for a term of three years or until his successor is appointed."

Amend Article XII, Section 2, by striking out "After consideration of the merits of the case."

INFORMATION COMMITTEE REPORTS

The following reports were distributed in writing for the information of the meeting and an opportunity was afforded at this time to raise any questions:

Report of the Delegates to the American Medical Association—Robert vL. Campbell, MD, J. Sheldon Eastland, MD, Russell S. Fisher, MD, December, 1966, Clinical Meeting
Secretary—William A. Pillsbury, MD
Board of Medical Examiners—Frank K. Morris, MD, Secretary
Executive Secretary—Mr. John Sargeant
Library and History Committee and Finney Fund Committee—Louis Krause, MD, and D. C. W. Finney, MD
Curator—Edwin David Weinberg, MD
Committee on Program and Arrangements—James B. Brooks, MD
American Medical Education and Research Foundation Committee—William S. Stone, MD
Committee on Contractual Arrangements—Belden R. Reap, MD
Economics Committee—Paul F. Guerin, MD
Editorial Board, *Maryland State Medical Journal*—C. Thomas Flotte, MD
Committee on Emotional Health—Augusto J. Esquibel, MD
Fee Schedule Committee—William G. Speed, III, MD
Finance Committee—Karl F. Mech, MD
Legslative Committee—Martin Middleton, MD
Liaison Committee—William L. Stewart, MD
Maryland Medical Service, Board of Trustees—J. Sheldon Eastland, MD, President
Med-Chi Insurance Trust—Paul F. Guerin, MD
Mediation Committee—Wolcott L. Etienne, MD
Medical Emergency Disaster Service Committee—Charles J. Savarese, MD
Medicolegal Committee—Howard F. Kinnamon, MD
Membership Committee—Nathan E. Needle, MD
Occupational Health Committee—John R. Davis, MD
Policy and Planning Committee—Eldridge H. Wolff, MD
Public Relations Committee—Manning W. Alden, MD
Representatives on the Medical Advisory Committee of the Red Cross Blood Bank Program.

LEGISLATIVE COMMITTEE COMMENDATION

Dr. Mech moved, "That the Legislative Committee and, in particular, its chairman, Dr. Middleton, be commended for the outstanding work done at the General Assembly session in Annapolis during 1967 and that the House also express commendation to the Executive Secretary for the fine work in this area." The House unanimously adopted such a commendation.

ADJOURNMENT

There being no further business, the House adjourned at 10:45 AM.

WILLIAM A. PILLSBURY, MD, Secretary

ELECTION OF THE BOARD OF MEDICAL EXAMINERS OF MARYLAND

A general meeting of the Medical and Chirurgical Faculty was held on Thursday, April 20, 1967, at 12:15 PM at The Alcazar, Cathedral and Madison Streets, Baltimore, for the purpose of electing two members of the Board of Medical Examiners of Maryland.

The President, J. Morris Reese, MD, presided and called the meeting to order.

The names of the two nominees were presented to the General Meeting, as follows:

John H. Hornbaker, MD (June, 1967-June, 1971)
Frank K. Morris, MD (June, 1967-June, 1971)

Nominations from the floor were requested. There being none, the Chairman declared nominations closed.

Elections took place by acclamation, and the Secretary, William A. Pillsbury, MD, was instructed to cast one ballot for those nominated.

There being no further business, the meeting adjourned at 12:30 PM.

WILLIAM A. PILLSBURY, MD, Secretary

MINUTES

The 257th meeting, second of the 169th Annual Session, of the House of Delgates of the Medical and Chirurgical Faculty of the State of Maryland, was held at the Faculty Building, 1211 Cathedral Street, Baltimore, Maryland, at 2:10 PM, Friday, April 21, 1967, the President and Secretary being present.

The following delegates (or alternates) were registered as being in attendance; an asterisk indicates an alternate delegate:

Doctors: Manning W. Alden, Council; Robert G. Angle, Montgomery County; Timothy D. Baker, Baltimore City; John G. Ball, Montgomery County; Richard D. Bauer, Council; *Philip J. Bean, St. Mary's County; Donald W. Benson, Baltimore City; M. McKendree Boyer, Past-President; Henry A. Briele, Council; Read N. Calvert, Montgomery County; Robert vanL. Campbell, Council; Douglas G. Carroll, Baltimore City; Robert G. Chambers, Baltimore City; *Katherine A. Chapman, Montgomery County; Henry V. Chase, Council; H. Douglas Cooper, Wicomico County; *Kenneth Cruze, Montgomery County; William B. Culwell, Carroll County; Henry V. Davis, Cecil County; Melvin B. Davis, Baltimore County; John B. DeHoff, Baltimore City; DeWitt E. DeLawter, Montgomery County; Everett S. Diggs, Council; J. Sheldon Eastland, Council; William Carl Ebeling, Council; Emanuel S. Ellison, Baltimore City; Robert W. Farr, Council; James McC. Finney, Hartford County; Vincent J. Fiocco, Jr., Carroll County; Russell S. Fisher, Council; *William E. Gilmore, Baltimore City; *Wilmer K. Gallager, Jr., Baltimore County; Harold H. Gist, Washington County; William B. Hagan, Council; William G. Helfrich, Baltimore City; Thomas F. Herbert, Howard County; James R. Karns, Baltimore City; Lauriston L. Keown, Baltimore City; Bender B. Kneisley, Past-President; Edward L. J. Krieg, Baltimore County; C. Rodney Layton, Queen Anne's County; Herbert H. Leighton, Garrett County; *Leon R. Levitsky, Prince George's County; Charles H. Ligon, Montgomery County; *James McCarter, Dorchester County; William J. McClafferty, Baltimore City; Karl F. Mech, Council; B. Martin Middleton, Council; Donald W. Mintzer, Baltimore City; Frank K. Morris, Board of Medical Examiners; G. Allen Moulton, Jr., Allegany County; Clayton Norton, Anne Arundel County; Charles F. O'Donnell, Council; Hilary T. O'Herlihy, Anne Arundel County; William A. Pillsbury, Jr., Council; Frank E. Poole, Wicomico County; J. Emmett Queen, Council; Belden R. Reap, Sr., Montgomery County; J. Morris Reese, Council; Guy M. Reeser, Jr., Talbot County; Thomas Reid, Frederick County; Paul F. Richardson, Baltimore City; *James A. Roberts, Montgomery County; Raymond C. V. Robinson, Baltimore City; Donald J. Roop, Council; Edwin Ruzicka, Talbot County; John F. Schaefer, Council; Emmanuel Schimunek, Baltimore City; Thaddeus C. Siwinski, Baltimore County; *Gordon M. Smith, Montgomery County; Aaron C. Sollod, Baltimore City; Omar D. Sprecher, Jr., Washington County; E. L. Suarez-Murias, Baltimore City; *Frank J. Townsend, Jr., Worcester County; Aaron H. Traum, Montgomery County; Thomas E. Van Metre, Jr., Baltimore City; Merton T. Waite, Anne Arundel County; Emerson C. Walden, Baltimore City; Hugh W. Ward, Calvert County; J. Arthur Weinberg, Council; Lawrence R. Wharton, Jr., Baltimore City; Daniel Wilfson, Jr., Baltimore City; Charles H. Williams, Baltimore County; Eldridge H. Wolff, Council; Donald O. Wood, Baltimore County; Charles E. Wright, Frederick County; John D. Young, Jr., Baltimore City; Raymond M. Yow, Council.

Present also for the meeting were staff personnel.

The President made several announcements regarding the transaction of business at the meeting and for information of the delegates.

ELECTION OF OFFICERS

There being no candidates nominated from the floor and there being only one candidate for each of the positions to be filled by unanimous consent the ballot was dispensed with. The following were then elected by voice vote:

President-elect
Arthur G. Siwinski, Baltimore (President-elect 1967-68; President 1968-69)
First Vice-president
Henry A. Briele, Salisbury
Second Vice-president
Wolcott, L. Etienne, College Park
Third Vice-president
George O. Eaton, Baltimore
Secretary
William A. Pillsbury, Timonium
Treasurer
Karl F. Mech, Baltimore
Councilors
John M. Dennis, Baltimore, Central District (1971)
Harry M. Robinson, Jr., Baltimore, Central District (1971)
Donald J. Roop, Baltimore, Central District (1971)
Raymond M. Yow, Salisbury, Eastern District (1971)
J. Parran Jarboe, La Plata, Southern District (1971)
Delegate to American Medical Association
J. Sheldon Eastland, Baltimore (Jan. 1, 1968-Dec. 31, 1970)
Alternate Delegate to American Medical Association
Robert C. Kimberly, Baltimore (Jan. 1, 1968-Dec. 31, 1970)
Committee on Program and Arrangements
John B. De Hoff, Baltimore (1972)
Library and History Committee
Robert B. Goldstein, Baltimore (1973)
Finney Fund Committee
Richard W. TeLinde, Baltimore (1973)

TREASURER'S SUPPLEMENTAL REPORT

Dr. Mech, Faculty Treasurer, was granted permission to announce that an additional sum had been added to the George M. Boyer, MD, Lecture Fund during 1966, and he wished to apprise the House of this fact. He also introduced Mr. Joseph Harrison who acts as Office Manager and Assistant to the Executive Secretary for financial affairs.

INTRODUCTION OF GUESTS

The President introduced J. Everett McClenahan, MD, president of the Pennsylvania Medical Society and Richard E. Flood, MD president of the West Virginia Medical Society.

REFERENCE COMMITTEE REPORT

Dr. Diggs, on behalf of the Reference Committee, reported to the House with respect to Resolution 1A/67, and recommended that it NOT be adopted.

RESOLUTION 1A/67 REJECTED

The House on division vote of 34 in the affirmative and 42 in the negative, rejected Resolution 1A/67, which read as follows:

Whereas, Maryland Medical Service, Incorporated, indicates in its Participating Physicians, Manual, at page 26 (Rev. 2-66) that benefits will be available to its subscribers for diagnostic x-ray services only when such services are performed by physicians conforming to certain criteria established by Maryland Medical Service, Incorporated; and

Whereas, The proper practice of medicine requires the exercise of all of a physician's skills and qualifications; and

Whereas, The condoning of such regulation of medical practice by economic means may lead to further propagation of such restrictions, which are contrary to the best interest of the patient; and

Whereas, Such restrictions are not imposed upon Maryland physicians by licensure; now, therefore, be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland condemns any attempt by any insurance company to determine for its subscribers which duly licensed physician is qualified to perform what medical procedure and requests that all insurance carriers doing business in this State amend their regulations accordingly.

RESOLUTION 2A/67 REJECTED

Dr. Diggs, on behalf of the Reference Committee, recommended that Resolution 2A/67 NOT be adopted. The House rejected Resolution 2A/67, which read as follows:

Whereas, The goal of the medical profession, i.e. to obtain the highest possible standard of health and the greatest improvement of medical practice for the public's benefit, may finally be won through enabling the patient to have his own chosen doctor treat him at any institution he chooses (including hospitals), within the state limits; and

Whereas, This type of private practice of medicine is the objective of our Medical and Chirurgical Faculty; and

Whereas, Corporate Private practice of medicine is not permitted in Maryland; and

Whereas, Corporate control, intervention or denial in the private practice of medicine is not in the best interest of or for the benefit of the public's health and welfare; and

Whereas, Our laws regarding the public's health and welfare should be more definitive in this regard; and

Whereas, The medical profession being the only one having intimate and detailed knowledge of the requirements, standards and qualifications of the profession to practice medicine for the public's health and welfare; and

Whereas, The State authorizes only its Board of Medical Examiners in cooperation with the Medical and Chirurgical Faculty and the profession, to qualify, license, regulate and control the practice of medicine throughout Maryland; now, therefore, be it

Resolved, That the Legislature authorize only the State Board of Medical Examiners to be so constituted as to enable it to thoroughly accomplish its purpose and fully assume its sole activity and responsibility, and thereto enact the following:

"There shall be a Maryland State Board of Medical Examiners composed of at least eight (8) active members and it shall have such powers, duties, officers and meetings as are provided from time to time by law. This Board shall be so constituted as to qualify and license not only new members of the profession, but also be assisted in determining the qualifications of members in the Specialties by corresponding Specialists in their respective fields, with the advice and approval of the entire profession in the state.

"The Maryland State Board of Medical Examiners shall be elected by a majority vote of the general voting membership of the Medical and Chirurgical Faculty of Maryland and other eligible doctors in good standing in the state, voting by secret ballot through the mail.

"One-fourth of the members of the Board of Medical Examiners shall be nominated one month before the annual election of officers and delegates by the nominating committee of the House of Delegates; and, additional nominations may be made at a corresponding time by physicians in good standing at component society meetings, from the floor. These nominations shall be circulated to the entire general voting membership of the Medical and Chirurgical Faculty and be available to all physicians in good standing in the State; and, election of the members of the Board of Medical Examiners (as well as delegates and other officers) shall be by secret ballot through the mail. The elected Board members shall serve for a term of four years, or until their successors are elected and qualified, beginning on the first day of June following their election, or as provided by law.

"The State Board of Medical Examiners and its Qualifying and Disqualifying Boards shall be so constituted and after due process of consultation, with the advice and assistance of the Medical and Chirurgical Faculty; and, in compliance with parliamentary procedure and statutory laws and medical ethics, shall have the sole and complete authority and responsibility to qualify, disqualify, license, control and regulate the entire Practice of Medicine, Surgery and the Specialties, everywhere and anywhere in the State of Maryland; and, no other bodies, including individuals, hospitals or other corporations, groups, or branches of Government, shall have authority and responsibility to qualify, disqualify, license, control, regulate, deny, interfere with or intervene in the above, directly or indirectly, without specific definitive legislation to that effect, as noted at present relative to the Health Commissioners.

"The state and its components shall not be contractual parties with or give tax supported financial or subsidized aid in any form to any hospital, institution or other corporation, or group participating in medical practice which denies the State Board of Examiners' properly qualified and licensed doctors in good standing, the use of their beds and facilities for their private practice of medicine.

"If financial support or subsidy, including a tax-free status, is granted to such a body; and, it in turn in its contracts with hospitals or other institutions, bodies or groups, permits discrimination against doctors in good standing and refuses them the right to practice on their private patients by denying them access to the beds and facilities; or, requires of the doctors signed applications to abide by the hospital or corporate Bylaws and control of the practice of medicine; state contracts, financial support, subsidy or tax-free status shall be cancelled."

RESOLUTION 3A/67 REJECTED

Dr. Diggs, on behalf of the Reference Committee, recommended that Resolution 3A/67 NOT be adopted. The House rejected Resolution 3A/67 which read as follows:

Whereas, Medicaid extends full benefits to our indigent people in Maryland; and

Whereas, The best care of the growing infant and child can be given by the family physician or pediatrician, who can watch the child in its good and bad days, and develop a personal relationship with the child and the family which will enable him to treat the child better if sickness develops; and

Whereas, It seems that the so-called well baby clinics, which specialize in administering immunizations and observing growth of the normal child, have no more justification and no further part to play although the contributions of these clinics in the past, when indigent mothers had difficulty obtaining services of private physicians, were outstanding; now, therefore, be it

Resolved, That the Medical and Chirurgical Faculty go on record favoring closure of all well baby clinics and transfer of their patients to private physicians.

RESOLUTION 4A/67 TABLED

Dr. Diggs, on behalf of the Reference Committee, recommended that Resolution 4A/67 be adopted. On motion of Dr. Vail Robinson the House voted that Resolution 4A/67 BE LAID ON THE TABLE. It read as follows:

Whereas, The progressive development of individuals and communities requires freedom from infringements against life, liberty and pursuit of happiness; and

Whereas, To assure freedom from such infringements, governments and governing bodies, with the consent of the governed, properly enact laws, rules and regulations; and

Whereas, Disrespect to law and order, and disobedience of properly enacted laws, rules and regulations leads to demoralization of individuals and deterioration of civilized communities; now, therefore be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland hereby reaffirms its wholehearted support of all properly enacted laws, rules and regulations, and encourages its members to respect and obey them, demonstrating to their fellow-citizens, particularly the youthful, an example of obedience to the letter and spirit of the laws of the land; and be it further

Resolved, That the members of the Medical and Chirurgical Faculty of the State of Maryland, individually and collectively, hereby state, that whenever any law, rule or regulation comes to their attention as being probably improper or probably not conducive to the progressive development of citizens or communities, it is their intent to bring about correction of such impropriety through the democratic processes which represent the proud heritage of American citizens, but to obey such directives until they are properly changed.

RESOLUTION 5A/67 ADOPTED AS AMENDED

Dr. Diggs, on behalf of the Reference Committee, recommended that Resolution 5A/67 be adopted as altered by the Committee with the consent of the sponsor. The House, after debate and further amendment, adopted Resolution 5A/67, as follows:

Whereas, The Medical and Chirurgical Faculty of the State of Maryland has shown, its deep continuing concern with the maintenance of high standards of medical practice, thus ensuring public confidence in the medical profession; and therefore be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland take the initiative and reiterate again the Faculty's offer of assistance to the State Health Department in the maintenance of high standards of medical parctice in the provision of medical services through Maryland's Title 19 program of medical assistance.

TITLE 19 RESOLUTION

Dr. Mech was granted leave by a 2/3 vote under Article VI, Section 4, of the Bylaws to introduce the following motion which was unanimously adopted by the House:

That a telegram be despatched today to the Governor of Maryland, affirming physician support of the Title 19 Medical Care Program, but expressing grave concern over apparent inadequate budget appropriations for successful and complete operation of Title 19 Program. And that copies be sent to the Senate President and House Speaker.

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RECOGNITION OF MR. WALTER N. KIRKMAN

Dr. Mech then requested recognition by the House that Mr. Walter N. Kirkman was not able to be present at this session, the first one missed by him in many years, because of illness. The House recognized this and expressed its concern over the illness.

ADJOURNMENT

There being no further business, the President made several announcements, following which he introduced to the House of Delegates the new President, Richard D. Bauer, MD, who assumed the Chair.

After comments and acceptance remarks, the new President by unanimous consent declared the House adjourned *sine die,* at 3:00 PM.

WILLIAM A. PILLSBURY, MD, Secretary

REPORTS

To The House of Delegates

April, 1967

All recommendations in **bold type.**

COUNCIL

Mr. President and Members of the House of Delegates:

Both the Council and the Executive Committee met in lengthy sessions on a regular basis during the past year. All of these meetings were summarized in the *Maryland State Medical Journal* for the information of all members.

Physicians' Defense was ratified for some 33 cases during the past year. There is a continued rise in the number of physicians being sued and more and more of these suits are resulting in substantial verdicts or settlements. To cope with this, an Ad Hoc Committee is being formed to prepare an educational program for Faculty members.

The Council received funds from the publishers of books of Henry P. Laughlin, MD, as well as, an additional sum of $1,500 from M. McKendree Boyer, MD, to be added to the George M. Boyer, MD Lecture Fund.

The Council highlights for the year included:

1. Continued meetings with the Executive Committee of the Hospital Council for discussion of mutual problems.
2. Made certain recommendations to the Governor for various appointments to boards, commissions, councils, and agencies.
3. Designated representatives to an Arbitration Committee for the Edward W. McCready Memorial Hospital, Crisfield, Md.
4. Received a portrait of the late Edgar B. Friedenwald, MD, from his son.
5. Spent many hours hearing charges against Leonard Flax, MD, and reached a decision on the matter which has been appealed to the Judicial Council of the AMA.
6. Discussed various provisions of the Title 19 program with health department representatives; and also with The Johns Hopkins Hospital representatives.
7. Discussed, approved, and considered various recommendations from committees.

Emeritus membership is recommended for the following:

Philip J. Hirshman, MD, Washington County

Respectfully submitted,
Russell S. Fisher, MD, Chairman

SECRETARY

Mr. President and Members of the House of Delegates:

During the past year, the steady increase in the amount of correspondence handled has continued. In addition, the Faculty now handles the dues billing for all component societies, remitting to them the dues collected on their behalf. Dues of the AMA are also remitted to Chicago. Membership in the AMA totalled 2,434 for the year 1966.

During the past year, staffing was provided for all committee and subcommittee meetings. Minutes were written for these sessions, and sent out together with meeting notices and other material. Complete records of all these meetings are available at the Faculty office and provide continuity and background for new chairmen as they take office. In 1966 a total of 415 meetings was held in the Faculty building, in addition to the regular medical examinations held by the Board of Medical Examiners.

Respectfully submitted,
William A. Pillsbury, MD

EXECUTIVE SECRETARY

Mr. President and Members of the House of Delegates:

The work results of the office staff are reflected in the various committee reports, as well as the smooth functioning of the office tasks.

Hopefully, all inquiries received are answered promptly, courteously, and with complete information. It is assumed that this occurs, as nothing to the contrary has been reported to me.

Several employee changes took place during the year. This has resulted in additional work loads for some of our staff. In addition, the tremendous changes that are taking place in medicine today have forced additional duties and responsibilities on us.

Additional calls for attendance at meetings, both intra- and inter-professional, have placed an unduly heavy load on time.

In closing, I may state that I look forward to many more years of happy association with the Faculty; and also express appreciation to the devoted and loyal staff members who make my work that much easier.

Respectfully submitted.
John Sargeant

AMERICAN MEDICAL ASSOCIATION EDUCATION AND RESEARCH FOUNDATION COMMITTEE

Mr. President and Members of the House of Delegates:

In 1966, Maryland physicians gave $9,510.00 to medical education through the AMA-ERF. A check was formally presented at the AMA clinical meeting in Las Vegas by Russell S. Fisher, MD, Maryland delegate to the AMA.

From the national total collected in 1966, the University of Maryland School of Medicine receives $15,678.69 and The Johns Hopkins University School of Medicine receives $9,517.64. As has been the custom, the checks will be presented to the deans of the respective medical schools at the Presidential Dinner.

Respectfully submitted,
William S. Stone, MD, Chairman
Newland E. Day, MD
Abraham Genecin, MD
William B. Gunther, MD
Bender B. Kneisley, MD
J. Douglass Shepperd, MD
Vernon M. Smith, MD
Thomas B. Turner, MD

BOARD OF MEDICAL EXAMINERS

Mr. President and Members of the House of Delegates:

Examinations given during the year show the following results:

Applications received for examination		625
Second year students examined	116	
Postponed, withdrawn or did not appear	89	
Failed to complete	2	
Re-examined after license to meet requirements of other states	1	
Not eligible for license		208
Examined in second part of exam	114	
Complete examination	193	
Re-examined	110	
Eligible for license		417
Passed—American Graduates	145	
Passed—Foreign Graduates	168	
Failed—American Graduates	11	
Failed—Foreign Graduates	93	417
The American schools which had failures are as follows:		
Howard Univ.	5	
Johns Hopkins	3	
Univ. of Maryland	1	
Stritch Medical School	1	
Univ. of Washington	1	
Licenses issued after examination	417	
Licenses issued by endorsement of other states' licenses	163	
Licenses issued by endorsement of National Board Certificate	244	
Total licenses issued	824	
Licenses revoked or suspended	0	
License restored	1	
Licentiates certified to other states	263	
Copies of licenses issued	29	
American graduates examined and re-examined	150	
Foreign graduates examined and re-examined	267	
Foreign graduates approved for examination	169	
Written inquiries from foreign graduates (approx.)	584	
Office interviews with foreign graduates (approx.)	275	
Telephone inquiries from foreign graduates (approx.)	1,600	
Telephone inquiries concerning registration of physicians	2,500	
Written inquiries concerning registration of physicians (approx.)	500	
6/1/63-6/1/66 Registration certificates issued to 5/30/66	11,084	
1966-69 Registration certificates issued to 12/31/66	8,380	

Hearings

Ulysses G. Bourne, MD, was charged with having violated Federal Law by selling pep pills. After considering the testimony, the Board decided to take no further action, and considered the case closed.

The license of Bennett A. Robin, MD, was revoked in 1965. He appealed, and the appeal was withdrawn on May 1, 1966. His Maryland medical license was restored on August 1, 1966.

Reprimanded

Ralph F. Young, MD, was notified that the Board of Medical Examiners of Maryland have relieved him of further responsibility to the Board in connection with the hearing on revocation and the case is now closed.

Carlos Arrabal, MD, was reprimanded for dispensing drugs illegally on which charges he was placed on probation without verdict. He has been reprimanded by this Board and is reporting periodically to the Executive Committee at three month intervals to give an account of his professional activities and moral character.

Yuen K. Yuan, MD, is still reporting to the Executive Committee to give an account of his professional activities.

John Richard Smith, MD, was notified that he would no longer be required to report to the Executive Committee to give an account of his professional activities.

Rent

As noted in the Summary of Activities January 1, 1966 to March 1, 1966, the rent for Osler Hall was increased from $80.00 to $125.00 beginning January 1, 1967.

Senate Bill 143 was passed empowering the Board of Medical Examiners of Maryland to provide for suspension or placing physicians on probation.

Sixty-Second Annual Congress of Medical Education and Licensure

Doctors Walter C. Merkel, Vernon H. Norwood, and Frank K. Morris representing the Board attended the Congress held in Chicago February 5 to 8, 1966.

Notification of Hearing

The Medical and Chirurgical Faculty will be notified of the date of hearing for restoration of a Maryland medical license.

Third Triennial Registration

The third Triennial Registration began June 1, 1966, known as the "C" registration.

Respectfully submitted,

FRANK K. MORRIS, MD, Secretary
JOHN H. HORNBAKER, MD
KARL F. MECH, MD
WALTER C. MERKEL, MD
WILBER R. ELLIS, JR., MD
VERNON H. NORWOOD, MD
ELMER G. LINHARDT, MD
WILLIAM L. STEWART, MD

BYLAWS COMMITTEE

Mr. President and Members of the House of Delegates:

The Bylaws Committee has had one meeting to consider Bylaws changes. These are presented herewith for action by the House of Delegates:

Amend Article I, Section 1, by adding: "Membership in a component society shall carry with it membership in the appropriate class of membership in the Faculty."

OLD

Section 1. All medical societies of the Maryland counties and Baltimore City chartered by the Faculty shall constitute the component societies of the Faculty.

NEW

(CAPS portion to be added)

Section 1. All medical societies of the Maryland counties and Baltimore City chartered by the Faculty shall constitute the component societies of the Faculty. MEMBERSHIP IN A COMPONENT SOCIETY SHALL CARRY WITH IT MEMBERSHIP IN THE APPROPRIATE CLASS OF MEMBERSHIP IN THE FACULTY.

Explanation: Because this question of compulsory membership in the Faculty is being raised continually, and despite various legal and parliamentary rulings on it, it is felt that this should be in the Bylaws so as to ensure there is no misunderstanding on this point.

Amend Article II, Section 4, by striking out the word "active" before the word "members."

OLD

(*Italicized portions to be deleted*)

Section 4. EMERITUS MEMBERS shall consist of those *active* members who, upon the request of their component societies and recommendation by the Council, shall be so designated by majority vote of the House of Delegates. They shall be (1) members no longer engaged in the practice of medicine, either in private practice, public health, administration, teaching or any other activity where their knowledge of medicine earns them an income; or (2) members whose health is such that their ability to carry on active practice has become greatly limited. They shall have the rights accruing to associate members. They shall not be entitled to physicians' defense unless the alleged malpractice occurred during their tenure as active members.

NEW

Section 4. EMERITUS MEMBERS shall consist of those members who, upon the request of their component societies and recommendation by the Council, shall be so designated by majority vote of the House of Delegates. They shall be (1) members no longer engaged in the practice of medicine, either in private practice, public health, administration, teaching or any other activity where their knowledge of medicine earns them an income; or (2) members whose health is such that their ability to carry on active practice has become greatly limited. They shall have the rights accruing to associate members. They shall not be entitled to physicians' defense unless the alleged malpractice occurred during their tenure as active members.

Explanation: No provision exists for making Associate Members Emeritus Members of the Faculty. This amendment will provide for this.

Amend Article III, Section 4, by striking out the second sentence and inserting: "Any member whose dues are unpaid by March 1 each year shall be deemed to be not in good standing and shall forfeit all rights in the Faculty and its components, and shall not be reinstated until after the Annual Meeting and all arrearages are paid. If the member's dues are not paid up by December 31 of that year he shall be dropped from the roll of members."

OLD

(*Italicized portions to be deleted*)

Section 4. Any component society failing to comply with Section 1 of this Article by March 1 each year may be suspended and forfeit all rights in the Faculty. *Any member whose dues are unpaid by March 1 each year shall be deemed suspended and forfeit all rights in the Faculty and shall not be reinstated until after the Annual Meeting and all arrearages are paid.*

NEW

(CAPS portion to be added)

Section 4. Any component society failing to comply with Section 1 of this Article by March 1 each year may be suspended and forfeit all rights in the Faculty. ANY MEMBER WHOSE DUES ARE UNPAID BY MARCH 1 EACH YEAR SHALL BE DEEMED TO BE NOT IN GOOD STANDING AND SHALL FORFEIT ALL RIGHTS IN THE FACULTY AND ITS COMPONENTS, AND SHALL NOT BE REINSTATED UNTIL AFTER THE ANNUAL MEETING AND ALL ARREARAGES ARE PAID. IF THE MEMBER'S DUES ARE NOT PAID BY DECEMBER 31 OF THAT YEAR HE SHALL BE DROPPED FROM THE ROLL OF MEMBERS.

Explanation: Again, the current procedure is as outlined in the new, proposed Bylaws. Because it should be clearly spelled out as to what rights and benefits a member has; and because it should be clear to the staff as to what procedure is to be followed, this amendment is proposed for adoption.

Amend Article VII, Section 2, Clause 9, by substituting for it the following: "Appoint an Editor of the *Maryland State Medical Journal* for a term of three years or until his successor is appointed."

OLD

(*Italicized portions to be deleted*)

Section 2. . . . (9) appoint an Editor and Business Manager of the Maryland State Medical Journal;

NEW

(CAPS portion to be added)

SECTION 2. . . . (9) APPOINT AN EDITOR OF THE *MARYLAND STATE MEDICAL JOURNAL* FOR A TERM OF THREE YEARS OR UNTIL HIS SUCCESSOR IS APPOINTED.

Explanation: Because the functions of the Business Manager are carried out by the accounting department of the Faculty; and because all Faculty appointments to offices carry a term with them, the Bylaws Committee recommends adoption of this amendment.

Amend Article XII, Section 2, by striking out "After consideration of the merits of the case,".

OLD (*Italicized portions to be deleted*)	*NEW*
Section 2. *After consideration of the merits of the case,* on a majority vote, the Council may authorize physicians' defense and the matter shall be referred to an attorney-at-law retained by the Council for a term of one year.	Section 2. On a majority vote, the Council may authorize physicians' defense and the matter shall be referred to an attorney-at-law retained by the Council for a term of one year.

Explanation: Because the Council is not in the position of making an adequate judgment of "the merits of the case," and because the current procedure followed does not, in fact, do this, the Bylaws Committee recommends the adoption of this amendment to bring the Bylaws into accord with the procedure followed.

Respectfully submitted,
Charles F. O'Donnell, MD, Chairman
Edmond J. McDonnell, MD
B. O. Thomas, Jr., MD
Raymond M. Yow, MD

CONTRACTUAL ARRANGEMENTS COMMITTEE

Mr. President and Members of the House of Delegates:

The Committee on Contracutal Arrangements has held only two formal meetings since it was organized in early 1966. One was for the purpose of surveying the various specialty groups and ascertaining the problems, if any, within those groups.

The other meeting was held to report to committee members progress being made in the elimination of payment for professional services from the Blue Cross contract and transfer of such payment to the Blue Shield contract. Several meetings were held with the Faculty's committee chairman acting as a catalyst in bringing together all interested parties to discuss this problem. Representatives of the Hospital Council, Blue Cross, Blue Shield, Pathologists, Radiologists, and others were all in attendance.

These meetings proved fruitful and, at this time, we believe served a useful purpose. It is hoped that the end result will be a satisfactory solution of this entire matter.

Respectfully submitted,
Belden R. Reap, MD, LLB, Chairman
Robert Z. Berry, MD
Stanley J. Bociek, MD
Donald H. Dembo, MD
Leonard J. Gallant, MD
Paul F. Guerin, MD
Theodore Kardash, MD
John G. Lyons, MD
Elliott Michelson, MD
William A. Niermann, MD
William B. Settle, MD
Albert Shapiro, MD
Charles E. Silberstein, MD
Henry H. Startzman, Jr., MD
Henry B. Wilson, MD

CURATOR

Mr. President and Members of the House of Delegates:

In accordance with a long-standing resolution of the House of Delegates, additional portrait restoration took place during the past year. The sum of $500.00 is budgeted on an annual basis for this purpose. Eventually, the Faculty's collection of portraits will be in first-class condition.

Several items of interest have been added to the Faculty's collection during 1966. Among these are additional gifts of material on the Laurel Sanitarium and a photograph of the graduating class, as well as a certificate and diploma, of the late Jesse C. Coggins, MD, presented by Mrs. Coggins, to whom we again express our appreciation. A portrait of Edgar B. Friedenwald, MD, was received from his son, Lt. Col. Aaron Friedenwald. Mrs. J. Mason Hundley, Jr., presented the Faculty with one of her late husband's "prized possessions"—an autographed photograph of Marion Sims, MD, and the book, "The Story of My Life" by Dr. Sims.

At the suggestion of Henry V. Chase, MD, Mrs. Mary Ann Sappington and Mrs. L. J. Call, Jr., presented the Faculty with a reproduction of a portrait of Francis Brown Sappington, MD, one of the founders of Med-Chi.

Several reprints of articles written by William J. Todd, MD, were received from his daughter, Mrs. Richard B. Webb and a gift of old instruments, etc., belonging to William Kelso White, MD, was donated by Mrs. White.

We wish to thank those members and non-members for their kindness in donating material of historical importance to our collection of memorabilia.

The Heart Association of Maryland had an attractive window display during the Flower Mart in Baltimore City this past year. The theme of the Mart was "Historic Baltimore" and much interest was created by the stethoscopes, lottery tickets, large medicine chest, case of instruments, gas lantern used in X-ray dark room, and an apothecary cabinet borrowed from the Faculty.

A medicine chest, saddle bags with medicine and a turnkey were borrowed by the Baltimore City Health Department for use to create a set—a doctor's office in the 1800's—for display on one of the TV shows of "Your Family Doctor."

Mrs. Elmer G. Linhardt borrowed the Dennis Claude diploma, Ehrich's Self Retaining Speculum, and a syringe owned by Upton Scott, MD, one of the Faculty founders, for an exhibit which she arranged at the American Society of Abdominal Surgeons in Chicago.

Respectfully submitted,
E. David Weinberg, MD, Curator

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Mr. President and Members of the House of Delegates:

Your three Delegates and the Senior Alternate Delegate to the American Medical Association's House of Delegates attended the 1966 Clinical Session held in Las Vegas from November 27-30, 1966, at which many items of interest were discussed. The following information is reported to the House for its information. Individual items have been referred to the appropriate Faculty Committees and Subcommittees for whatever action is deemed fit by them.

Education for family practice, billing and certification procedures under Public Law 89-97, proposed revisions of the Selective Service System, payments for professional services, compensation for house officers, and use of the terms "ethical" and "unethical" were among the major subjects acted upon by the House of Delegates at the American Medical Association's 20th Clinical Convention held November 27-30 in Las Vegas, Nevada.

Dr. Charles L. Hudson, AMA President, told the Monday opening session of the House that the need to improve existing services and establish new services for the total population should be a "top priority" of the medical profession. He proposed that the AMA and the state and county medical societies launch a continuing program, under predominantly private auspices, for all persons of whatever age, race, creed, or color, and he emphasized that it is "among the needy and formerly indigent that I feel we must show interest, initiative, and enterprise."

At the Wednesday session Dr. Robert Mayo Tenery of Waxahachie, Texas, general surgeon and past president of the Texas Medical Association, was elected to fill the unexpired term of the late Dr. William A. Hyland, ending June, 1969, on the Council on Constitution and Bylaws.

Final registration reached a grand total of 11,226, which was a record high for an AMA Clinical Convention, and that included 4,574 physicians, which was the third highest physician registration at a Clinical Convention.

Education for Family Practice

Calling it "a document of major importance on a subject of vital significance to the health care of the American public," the House of Delegates endorsed the recommendations of the Ad Hoc Committee on Education for Family Practice and authorized the Council on Medical Education to develop and initiate plans for their implementation. The long report contained the following recommendations:

"A. Major efforts should be instituted promptly to encourage the development of new programs for the education of large numbers of family physicians for the future, as described in the body of this report. The educational programs should relate to all levels of medical education, including premedical preparation, medical school education, internship and residency training, and continuing medical education. Keynotes should be excellence comparable to programs in other specialties and flexibility to permit the design of programs which will meet the needs and interests of individual physicians.

"B. Medical schools and teaching hospitals should be urged to explore the possibility of developing models of family practice, in cooperation with the practicing profession.

"C. New sources of financial assistance should be developed for the support of family practice teaching programs. Substantial funds should be made available for all aspects of the programs, including the conduct of the educational program, the recruitment and training of full-time faculty, the development of facilities and models of family practice, and the conduct of research in patient care and community medicine.

"D. Recognition and status equivalent to other medical specialties should be given to family practice. An appropriate system of specialty certification should be provided for those who have completed approved educational programs and have demonstrated their competence as family physicians. The graduate program (i.e., internship-residency program) should be an integrated whole, evaluated for accreditation by one body rather than two.

"E. Careful attention should be given to other factors which should make the environment for family practice more favorable and serve as incentives to medical students and young physicians to enter this field.

"F. Careful study should be made of the effect of premedical programs and the admission procedures, curricula and student evaluation policies of medical schools upon the production of family physicians."

Delegates and other interested AMA members also attended an open hearing Tuesday morning on the report of the Citizens Commission on Graduate Medical Education, which is similar in many respects to the report of the Ad Hoc Committee on Education for Family Practice. The Commission report is still under study by the AMA Board of Trustees and Council on Medical Education. The House of Delegates urged every physician and medical society to study the report (commonly called the "Millis Report"), to evaluate it, and to present comments and critique to the Board prior to the next session of the House.

Public Law 89-97

The House adopted a resolution urging that the American Medical Association advise the Department of Health, Education, and Welfare that the present requirements for certification and recertification have proven highly objectionable, unnecessary, and do not contribute to the quality of medical care.

It also recommended that the American Medical Association endeavor to bring about repeal of those portions of PL 89-97 in which the requirement for physician certification of medical necessity appears.

The resolution concluded by suggesting that the fiscal intermediaries and the American Hospital Association be advised that AMA will be available to assist in the development of appropriate amendments to this legislation. The purpose of this consultation would be to discuss the complexities of the present requirement and to invite participation in the development of amendments to the law which will be professionally acceptable and administratively workable.

The House also adopted a resolution declaring that the AMA strongly support amendment of the Social Security Act, including Title XIX, to permit payments without assignments for medical care of the patient.

The House rejected three resolutions and one report defining usual, customary, and reasonable charges. Instead, it adopted a resolution which said that the definitions of the words "usual," "customary," and "reasonable" be considered, within the fundamental framework of individual determination, the responsibility of the constituent state medical societies, with the understanding that the advice and counsel of the AMA be made available to those states requesting such assistance.

Selective Service Proposals

The House adopted a report seeking federal legislation to establish a National Commission on Health Resources and Medical Manpower. The commission would revise the "doctor draft" system and establish physician alloca-

tion priorities to maintain a proper balance of health personnel in civilian and government service.

The report, prepared by the Council on National Security, cited three basic flaws in the Selective Service System as it pertains to the selection of physicians for military service: 1) There is no medical group directing the allocation of physicians; 2) There is no medical group directing the priorities to be used for calling physicians to active duty; 3) There is a need for a stronger medical voice within the Department of Defense.

The proposed commission would be appointed by the President with consent of the Senate. It would replace the Health Resources Advisory Committee and the National Advisory Committee to Selective Service.

Prescribing of Drugs

The House adopted a report by the Board of Trustees reaffirming the position of the AMA regarding the prescribing of drugs. The report states:

"The present policy of the American Medical Association is that physicians should be free to prescribe drugs generically or by brand name for *all* of their patients, whether they are paying, Medicare, or indigent patients—the primary consideration being the best interests of the patient. Medical considerations must be paramount in the selection of drugs. In addition, the physician also has an obligation to be mindful of the economic consequences of the treatment he prescribes."

Choice of a Laboratory

The House adopted a report of the Judicial Council which answered questions which have been raised about laboratory services. The report stated:

"Medical considerations, not cost, must be paramount when the physician chooses a laboratory. The physician who disregards quality as the primary criterion or who chooses a laboratory because it provides him with low cost laboratory services on which he charges the patient a profit, is derelict in not acting in the best interests of his patient. However, if reliable quality laboratory services are available at lower cost, the *patient* should have the benefit of the savings."

Statement on Chiropractic

On recommendation of the Board of Trustees, the House adopted a policy statement submitted by the Committee on Quackery. The statement notes "the position of the medical profession that chiropractic is an unscientific cult whose practitioners lack the necessary training and background to diagnose and treat human disease" and pointed out that "decisions by the nation's highest courts [justify] the medical profession's educational program of alerting the nation to the public health threat posed by the cult of chiropractic."

Statement on Alcoholism

The House reaffirmed the 1956 policy statement on admission of alcoholics to general hospitals. The statement urged hospital administrators and medical staffs to look upon alcoholism as a medical problem and to admit patients who are alcoholics to their hospitals for treatment, with such admissions being made after due examination, investigation, and consideration of the individual patient. The House, in Las Vegas, recommended more adequate implementation of the 1956 statement and urged that "insurance companies and prepayment plans be encouraged to remove unrealistic limitations on the extent of coverage afforded for the treatment of alcoholism."

Payments for Professional Services

To clarify AMA policies as they now exist, the House adopted the following eight-point statement regarding payment for professional medical services:

"1. It is proper for the physician to establish the fee which he charges to any patient for the professional service rendered, with recognition of the fact that a duly constituted committee of his peers may appropriately review and pass upon the equity and justice of his charge.

"2. It is proper for third party agencies to make payment of professional medical fees in behalf of patients, with recognition of the fact that the service of the physician has been to the patient and the liability for payment rests primarily with the patient or his family.

"3. It is proper for a physician to work cooperatively with other physicians in a team approach to the provision of medical service, with recognition of the fact that each cooperating physician is entitled to compensation according to the value of his services, and that the charges attributable to each physician's service shall be made clearly known to the patient.

"4. It is proper for a physician who provides personal supervision and direction for a physician-in-training to charge for the professional medical service rendered.

"5. A physician should not enter into a contract or agreement with a hospital whereby the hospital acts as the agent for a physician unless it is with the consent of the physician and of the medical staff. The physician and the medical staff, as principals, should not approve any contract whose terms or conditions are inconsistent with the Principles of Medical Ethics and established policy of the American Medical Association.

"6. Physicians, collectively in hospitals, may properly establish special medical staff funds, wholly under their own control, which they may support as they see fit and disburse as they may agree.

"7. Fees for professional medical services are properly paid only to the responsible physicians and may not be appropriated by any other person or agency.

"8. The physician is the sole arbiter as to the ways in which he may dispose of his professional income, without duress, consistent with the laws of the land and the Principles of Medical Ethics of this Association."

Compensation for House Officers

The House approved the first four sections of a joint report by the Council on Medical Education and Council on Medical Service. Those sections provided new guidelines on the utilization of private patients in teaching programs; recommended principles to govern the assignment of professional responsibility of house officers for the care of paying patients; presented interpretations of the 1961 statements by the House concerning remuneration of house officers and the increasing responsibility of the medical profession for the development of appropriate methods of financial support for interns and residents, and recommended a statement to guide medical staffs in the development of additional funds to supplement, if necessary, those from hospital sources.

The House then modified or added the final four sections as follows:

E. The presently published provisions for payment under Part A, Title 18, Public Law 89-97 for services rendered to beneficiaries by interns and residents, and under Part B, Title 18, Public Law 89-97 for services rendered by attending physicians supervising interns and residents, are compatible with the organization and administration of programs of graduate medical education according to the standards of the American Medical Association. The principles embodied in these provisions should uniformly apply to regulations governing all other third party medical care plans.

F. It is recommended that sources and amount of compensation for house officers should be determined by local agreement and implemented in accordance with state laws and the ethical principles and policy positions of the American Medical Association.

G. The above principles should be widely publicized so that they may be understood and implemented in good faith by all concerned.

H. The broad and complex nature of the problems in the financial areas is recognized, and continued studies and reports thereon by the Council on Medical Service are encouraged. These should include staff compensation, methods of fund collection, control and disposition, and other pertinent and related matters.

Use of the Terms "Ethical" and "Unethical"

The Judicial Council, which had been asked to comment on use of the terms "ethical" and "unethical," submitted the following report which was adopted by the House:

"Historically, the term 'ethical' has been used in opinions and reports of the Judicial Council and in resolutions adopted by the House of Delegates to refer to matters involving (1) moral principles or practices; (2) customs and usages of the medical profession; and (3) matters of policy not necessarily involving issues of morality in the practice of medicine. The term 'unethical' has been used to refer to conduct which fails to conform to these professional standards, customs, and usages, or policies, as interpreted by the American Medical Association.

"Unethical conduct involving *moral principles,* values and duties calls for disciplinary action such as censure, suspension, or expulsion from medical society membership.

"Failure to conform to the *customs and usages* of the medical profession may call for disciplinary action depending upon the particular circumstances involved, local attitudes, and how the conduct in question may reflect upon the dignity of and respect for the medical profession.

"In matters strictly of a policy nature, a physician who disagrees with the position of the American Medical Association is entitled to freedom and protection in his point of view."

Other Actions

In considering 63 resolutions, 22 Board reports and a wide variety of additional reports and materials from councils and committees, the House of Delegates also:

Approved establishment of a new *Committee on Continuing Medical Education* but also urged that lines of authority be clearly defined by the Board of Trustees in consultation with the Council on Medical Education in order to avoid duplication of responsibilities already assigned to the Council;

Instructed AMA members of the Joint Commission on Accreditation of Hospitals to express grave concern regarding the accreditation of hospitals in which *laboratories* are directed by non-physicians or physicians not adequately qualified in laboratory medicine;

Passed two resolutions opposing the *"dual fee"* practice of determining the rate of payment for a physician's services solely on the basis of his type of practice;

Approved a Board report recommending that *Social Security* laws be amended so that physicians entering the program for the first time may obtain earlier eligibility and improved benefits;

Recognized the increasing importance of *medical society review committees,* reaffirmed the guidelines published in the November 29, 1965, issue of JAMA and endorsed additional principles recommended by the Council on Medical Service;

Urged continuing, vigorous effort to dissuade local officials from demanding that physicians sign civil rights *compliance statements* that are not required by law or by federal directives;

Recommended that state medical societies seek the passage of state legislation which would provide a physician who serves on a *utilization review committee immunity* from litigation arising from the activities of such committees;

Asked that the Board of Trustees direct the Council on Legislative Activities to continue to pursue with committees of Congress the need for amending the *Self-Employed Individuals Tax Act* to provide self-employed individuals with opportunities for deferring current earnings and taxes comparable to opportunities presently enjoyed by employed individuals;

Requested the Bureau of the Budget to modify the cost accounting system of *Veterans' Hospitals* to permit comparison with cost accounting in community hospitals to the end that economy, efficiency, and patient care can be properly assessed in Veterans' Hospitals;

Reaffirmed its support of the principle that every ethical licensed doctor of medicine who needs and desires them should have *staff privileges,* commensurate with his training and skill, in at least one accredited community hospital;

Recommended that each *hospital* should have at least one voting doctor of medicine member on its *Governing Board* who, preferably, should either be appointed or elected by the hospital medical staff from its membership;

Pointed out that there is a definite need for utilization committees and declared that *tax supported hospitals* and private hospitals should be governed by the same utilization standards;

Approved Board recommendations that "the AMA support the need for a significant improvement in the income of the *registered nurse*" and that "the AMA continue to support in principle all current nationally approved educational programs for nurses";

Agreed with the Board that the Council on Postgraduate Programs be renamed as the *Council on Scientific Assembly* and that its functions be redefined to enable concentration on AMA scientific meetings;

Adopted a resolution that the AMA take measures to insure the attention of medical societies to the need for appropriate utilization of *retired physicians and inactive nurses;*

Passed a resolution on the determination of *elderly applicants'* eligibility for automobile liability insurance and driver licensure which said that "although physicians are willing to examine applicants and determine whether or not the applicant meets specified physical standards for automobile liability insurance or for licenses to operate motor vehicles, the determination of what standards should be required or whether the driver is insurable and should be licensed to drive is the responsibility of the insurance companies concerned and of the state agencies issuing licenses, respectively";

Rescinded Resolution 104 which had been adopted by the House in June, 1966;

Endorsed the principle of *free choice* of physician and medical facility under Title XIX of Public Law 89-97;

Urged that the AMA continue to promote constructive legislation improving *existing governmental health plans* and continue to offer constructive advice;

Authorized the Board of Trustees to continue the *AMA Members Disability Program* beyond August 31, 1967; make every effort to continue the program with the same premium-benefit structure; clarify the existing program, and, if necessary, renegotiate a revised program which will be financially sound and will provide the best possible benefits and protection for present and future participants;

Approved a Board recommendation that no special section of *The AMA NEWS* be set aside for county society communications, but that news of county society activities continue to be an important part of *The AMA NEWS;*

Agreed with the Board that, effective January 1, 1967, the AMA should discontinue paying for the rental of the *TWX equipment* in state medical society offices;

Recommended that *driver education* should be an integral part of the secondary school curriculum and be offered to all students;

Approved a Council on Medical Service report providing guidelines for collaboration of physician, social worker, and lawyer in helping the *unmarried mother* and her child, and;

Referred to the Board, for consideration and appropriate implementation, a resolution urging the AMA to expand its programs and studies in the field of *crime prevention.*

Awards and Presentations

At the Monday opening session Dr. Milford O. Rouse, AMA president-elect and former speaker of the House, was presented with a mounted gavel in appreciation of his many years of service to the House and the Association.

Contributions totaling more than $500,000 were presented on Monday to the American Medical Association Education and Research Foundation. They were as follows: Merck Sharp and Dohme, $100,000; California Medical Association, $207,985; Illinois State Medical Society, $185,000; Utah Medical Association, $12,957.50; Medical and Chirurgical Faculty of Maryland, $9,110, and American Urological Association, $1,000.

Glen W. Geelhoed of Ann Arbor, a medical student at the University of Michigan, was announced on Tuesday as first-place winner in the Norman A. Welch, MD, Medical Ethics Essay Contest sponsored by the AMA Judicial Council. At the same session the delegates heard an address by Dr. Malcom E. Phelps, field director of the AMA Volunteer Physicians for Vietnam, who said that the American physician is making a "tremendous impression" on the South Vietnamese people.

Respectfully submitted,
Robert vanL. Campbell, MD
J. Sheldon Eastland, MD
Russell S. Fisher, MD
William B. Hagan, MD, Senior Alternate

ECONOMICS COMMITTEE

Mr. President and Members of the House of Delegates:

The Health Insurance Review Subcommittee of the Economics Committee met four times during the year and heard fourteen new cases of fee disagreement between major medical insurance carriers; eight reviews of settled cases; and two complaints registered by physicians against insurance carriers.

It was decided at the first session of the Subcommittee in the new year that as new inquiries are received at the Faculty office, surgical cases will be referred to a surgical member and medical cases to a medical member for advice. This information is then circulated to other members of the Subcommittee for comments with consensus transmitted to the insurance carrier.

It was also agreed, inasmuch as there are no psychiatrists on the Subcommittee, that in future cases involving psychiatric treatment, Jonas R. Rappeport, MD, would be asked to join the meeting for consultation.

As a result of study of a summary of cases handled by this Subcommittee since 1963, it was decided that representatives of the Health Insurance Council should be invited to a future meeting, along with representatives of the Maryland Medical Service, to discuss procedures used by carriers in arriving at their conclusions as to proper fees. The group feels that it provides an important service to the insurance industry in acting as arbiter and that in turn, the carriers should be reminded that they have an equal obligation to cooperate with the medical profession by not using harassing tactics.

Since 1963, a total of 31 cases had been handled by this Subcommittee with Aetna Life and Casualty and Maryland Hospital Services, Inc., leading in the number submitted by the eleven carriers. Medical Service of D.C. had the third highest number of cases submitted.

Respectfully submitted,
Paul F. Guerin, MD, Chairman
Arthur Baitch, MD
Gilbert L. Banfield, MD
Edward M. Barczak, MD
Harry J. Connolly, MD
W. Kenneth Mansfield, MD
Alfred S. Norton, MD
Eldridge H. Wolff, MD
Samuel H. Bryant, DDS

HEALTH INSURANCE REVIEW SUBCOMMITTEE: W. Kenneth Mansfield, MD, Chairman; Robert G. Chambers, MD, Julius Waghelstein, MD, Robert B. Goldstein, MD, Richard E. Hoover, MD.
ODMC SUBCOMMITTEE: Wilson Grubb, MD, Chairman; Barnett Berman, MD, Katherine H. Borkovich, MD, C. Holmes Boyd, MD, E. Ellsworth Cook, Jr., MD, Ernest I. Cornbrooks, Jr., MD, W. Bowdoin Davis, MD, Lieb S. Diamond, MD, Daniel Ehrlich, MD, Gerald A. Galvin, MD, M. Reza Hagigh, MD, Benjamin Highstein, MD, Theodore Kardash, MD, Louis F. Klimes, MD, Eugene J. Linberg, MD, Deonis M. Lupo, MD, J. Nelson McKay, MD, Ross Z. Pierpont, MD, Robert Sandler, MD, Charles E. Silberstein, MD, Albert J. Weiss, MD.

COMMITTEE ON EMOTIONAL HEALTH

Mr. President and Members of the House of Delegates:

The main areas of interest of the Committee centered on legislation, residency training in general hospital psychiatry, community mental health, and educational programs.

In the field of legislation, success was noted in the passage of the Patient/Psychiatrist Privileged Communication Bill, which was signed by the Governor on the last day bills which had been passed by the 1966 State Legislature could be signed.

On the other hand, the Committee recommended that the statement in the Reportable Disease law up before the 1967 Legislature relating to mental conditions be changed so as to delete the reporting by state mental hospitals of

all admissions and discharges. It was felt this involved a lot of work and would not cut down in any appreciable manner the number of traffic accidents. This statement was deleted from the proposed bill. In relation to this same legislation proposed by the Subcommittee on Traffic Safety (making certain physical and mental conditions reportable by physicians to the Medical Advisory Board of the Department of Motor Vehicles), motions were passed which would also delete the statement "any known, chronic, active alcoholic" since it was felt: (1) this would be medically undefinable; (2) laws already exist relating to this problem; and (3) treatment of such patients would be hindered.

The Committee further recommended that any person adjudicated incompetent be reported to the Department of Motor Vehicles by the Court or attorney, not by a physician, since "this is not a medical decision."

Finally, the Committee urged the Traffic Safety Subcommittee to consider more fully a more specific and definable reportable condition than implied in the phrase, "severe impairment of judgment."

A report was submitted on the training of psychiatric residents in general hospitals with no general agreement as to whether this is properly in the aegis of the Department of Mental Hygiene. It was suggested that in training the personnel at State Hospitals in general hospital psychiatry, the MEDIC system, as well as special visual aids and tape recordings, be used.

The Committee endorsed a proposal that some form of self-administered psychiatric test be made available at the Health Fair to be held at the Civic Center next year. This would be a good means of impressing the public with the need for concern with mental as well as physical health.

Consideration was given to the suggestion from the AMA that regional mental health conferences be held rather than national conferences. After discussion, the opinion was that regional conferences would not provide as much valuable information as national conferences, and therefore, the Committee voted against the suggestion.

No definitive action was taken on the need for transportation to hospitals of the mentally ill. This is, and has been, a constant problem in the state to which no feasible solution has yet been discovered.

The Committee also considered means of encouraging members of the Maryland Psychiatric Association not now members of the Medical and Chirurgical Faculty to join the latter. No action has yet been taken in this area.

No change in the policy of the Board of Medical Examiners for reciprocity licensing of foreign medical students was effected, the present procedure of hearing only special cases in which a doctor has a great deal of training being heard individually remaining in effect.

Respectfully submitted,

Augusto J. Esquibel, MD, Chairman
Irvin H. Cohen, MD
Irene L. Hitchman, MD
John Lertora, MD
Thurman Mott, Jr., MD
William J. Peeples, Jr., MD
Richard H. Pembroke, Jr., MD
Jonas R. Rappeport, MD
Kent E. Robinson, MD
Isadore Tuerk, MD

FEE SCHEDULE COMMITTEE

Mr. President and Members of the House of Delegates:

A great deal of time during the past year has been devoted to the concept of Usual, Customary, and Reasonable Fees to be paid physicians under various governmental programs. This principle is most important and it is hard to make the individuals responsible for such payment realize that physicians and the medical profession have been subsidizing such programs for many years.

After considerable discussion in this area with appropriate officials of state agencies it has been resolved with the Division of Vocational Rehabilitation, State Department of Education. Progress has also been made in the areas of discussions with the Workmen's Compensation Commission, as well as, the State Health Department.

Despite the recommendations of the State Health Department, a figure has been included in the 1968 fiscal budget for the Medical Care program that does not provide sufficient funds for payment on the basis of Usual, Customary, and Reasonable Fees. It is hoped that the funds included can be retained without reduction by the Legislature. Even if this is done, there will, in all probability, be a need for a supplemental State appropriation toward the close of the 1968 fiscal year.

Discussions have also been entered into with the State Health Department in connection with the lateness of payments and the arbitrary actions on the part of the Health Department in rejecting physicians' completed payment forms for medical care cases.

In June, 1966, the Committee requested permission from the Council to renegotiate the Dependents' Medical Care Program contract on the basis of Usual, Customary, and Reasonable Fees. After a meeting with representatives of the U. S. Armed Forces, and an abortive attempt to resolve how this would be administered, the Fee Schedule Committee recommended that this contract not be renegotiated and that Blue Shield be the fiscal intermediary for payment of physicians or patients under this program. This was approved by the Council in March, 1967.

An attempt was made to determine a definition of the term "reasonable," and this is still under study in the Committee.

During the year, various fees have been amended to conform with changing conditions. Additions and deletions to the Fee Guide have also been made. The most pressing objective of the Committee, at this time, however, is the principle that has been established by the House of Delegates. This is that all payments to physicians not be tied to schedules as such, but be on the basis of their Usual, Customary, and Reasonable Fees.

Respectfully submitted,

William G. Speed, 3rd, MD, Chairman
Katherine H. Borkovich, MD
Pierson M. Checket, MD
Archie R. Cohen, MD
John R. Davis, MD
Max C. Frank, MD
George H. Greenstein, MD
Wilson Grubb, MD
Richard E. Hoover, MD
John H. Hornbaker, MD
Robert W. Johnson, 3rd, MD

Tillman D. Johnson, MD
Watson P. Kime, MD
Alfred T. Lieberman, MD
Charles E. Loveman, DDS
Howard B. Mays, MD
John E. Miller, MD
Frank K. Morris, MD
William H. Mosberg, Jr., MD
Alfred T. Nelson, MD
Morris Perry, MD
Emmanuel A. Schimunek, MD
Lex B. Smith, MD
Edward S. Stafford, MD
William L. Stewart, MD
Morris J. Wizenberg, MD
Israel Zeligman, MD

Members of the PL 89-97 Liaison Subcommittee (Medicare):

Philip F. Wagley, MD, Chairman
John T. Chissell, MD
John C. Harvey, MD
Edmond J. McDonnell, MD
Belden R. Reap, MD, LLB

FINANCE COMMITTEE

Mr. President and Members of the House of Delegates:

The Finance Committee, which is commissioned to assist the treasurer in fulfilling his responsibilities, met in 1966 along with legal counsel to consider several matters of interest.

On advice of legal counsel, it was determined that the restriction on selling securities should be removed, and that securities may again be sold and purchased as recommended by T. Rowe Price, investment counselors.

The possibility of creating a Med-Chi Foundation was investigated and it was moved unanimously to table indefinitely such a concept. It was pointed out that such a foundation would have no tax benefits, inasmuch as the Faculty is already an Internal Revenue Service-approved non-profit organization for library facilities contributions, and that there is no specific, demonstrated need for such a foundation otherwise.

After discussion, the Finance Committee agreed that there should be no set policy for accepting contributions by donation or bequest, or for establishing special funds. Each proposal will be considered individually.

One such fund accepted was the assignment of royalty payments and other contributions as stated in the proposal of Henry P. Laughlin, MD, with certain provisos and recommendations.

Respectfully submitted,
Karl F. Mech, MD, Chairman
E. W. Ditto, Jr., MD
Louis J. Kolodner, MD
W. Kenneth Mansfield, MD
Raymond C. V. Robinson, MD

LEGISLATIVE COMMITTEE

Mr. President and Members of the House of Delegates:

The 1967 Legislative year has been one of the most active in the history of the Faculty. With a newly reapportioned legislature and most of the membership of the House and the Senate new, we have had to embark on an educational program to ensure that the medical profession is recognized as being the protectors of the public's health.

Careful scrutiny of all bills reveals that some 61 bills in the House and 44 bills in the Senate had some medical connotation. Everything from Chiropractic, Osteopathic, Abortion, Podiatry, and countless other health and health-related matters were considered.

In addition to the specific legislative matters and bills involved with this session of the legislature, it was necessary to actively participate in budget hearings in connection with the medical care program to ensure that funds for operation of this program remained intact.

An expression of thanks goes to all the physicians who so willingly gave of their time and efforts to appear before special and regular Committee Hearings in Annapolis. Without their assistance the successful prosecution of our task would have been impossible.

A summary of the most important bills in both the House and Senate is as follows:

HOUSE BILLS

House Bill 15.—Redefining the legal definition of sanity.

House Bill 19.—Change in the Nurses Practice Act to provide for stronger educational requirements; and to prohibit any but licensed persons from calling themselves "nurse."

House Bill 38.—Requiring physical testing of driving ability of drivers over 65 years of age; and requiring eye examinations for all drivers on occasion of license renewals.

House Bill 70.—Making it obligatory that all school bus operators have an initial physical examination and biennially thereafter.

House Bill 73.—Implied Consent law to provide for testing by blood alcohol level only.

House Bill 78.—Providing that non-profit institutions may not plead as a defense to a tort action the fact that it is non-profit.

House Bill 147.—Providing that certain records kept by the Department of Motor Vehicles shall be confidential as regards request for information from insurance carriers.

House Bill 187.—Making it a felony to sell or dispense amphetamines or barbiturates without a prescription, except by physicians, manufacturers in the regular course of practicing their profession or business.

House Bill 188.—Making it illegal to operate a motor vehicle while under the influence of amphetamines or barbiturates.

House Bill 189.—Creating the offense of selling, peddling, or dispensing amphetamines or barbiturates to minors.

House Bill 215.—Creating a Board of Dispensing Opticians, and authorizing certification of same.

House Bill 221.—Allowing Osteopaths to practice medicine and surgery.

House Bill 228.—Making it unlawful for persons under 18 to purchase "certain harmful substances" when not accompanied by parent or adult (fingernail polish, airplane glue, etc.).

House Bill 260.—Prohibiting inclusion of subrogation clauses as to medical payments in automobile liability policies.

House Bill 262.—Requiring attachment of anti-air pollution devices to exhaust systems of all new buildings and new improvements to buildings from which substances causing air pollution are exhausted.

House Bill 265.—Changing the compensation paid to members of Medical Advisory Board to Department of Motor Vehicles.

House Bill 272.—Creating additional nursing scholarships.

House Bill 276.—Providing for clarification of the present abortion law and providing that such abortions must be performed in a duly licensed hospital.

House Bill 338.—Requiring the Air Pollution Control Council to publish rules and regulations setting forth criteria for approval of motor vehicle pollution control devices.

House Bill 339.—Requiring mufflers adequate to prevent discharge of excessive fumes into ambient air.

House Bill 347.—Requiring warning to be placed on labels of certain drugs when consumption of alcoholic beverages may be harmful to health, and providing for penalty against physician who does not do so.

House Bill 359.—Requiring public and private agencies to furnish to the DMV names of persons receiving benefits, services, exemptions, or treatment as blind or nearly blind persons and authorizing cancellation of drivers' licenses of such persons.

House Bill 387.—Amending the law requiring certain injuries in Anne Arundel County to be added to the list where such must be reported to police.

House Bill 443.—Increasing beer tax, with such additional revenue to be allocated to the Department of Mental Hygiene to help defray the cost of treating alcoholics.

House Bill 449.—Authorizing Charles County to issue bonds for construction and equipping a non-profit nursing home.

House Bill 455.—Providing for a representative of the Maryland Nursing Home Association to be added to the Governors' Commission on Problems of the Aging.

House Bill 456.—Increasing the membership of the State Board of Health and Mental Hygiene by adding a representative of the propriety nursing homes in the State.

House Bill 473.—Establishing standards for "loss of hearing" in occupational compensation cases.

House Bill 506.—Implied Consent legislation—see similar bills in Senate and House.

House Bill 515.—Creating a Council on Hospital Affairs and giving it broad authority over hospital and health activities.

House Bill 531.—Adding chiropractors to the list for whom payment for services will be provided under the Medical Care program.

House Bill 537.—Requiring seat belts in all school buses.

House Bill 538.—Providing that individuals, physicians, and hospitals report certain diseases or conditions to the Medical Advisory Board, Department of Motor Vehicles.

House Bill 539.—Changing the visual acuity standards for motor vehicle licenses.

House Bill 541.—Providing that commercial insurance carriers may compensate chiropractors for services rendered.

House Bill 547.—Changing educational requirements for chiropractic licensure.

House Bill 572.—Providing for inspection without warrant of premises where dogs are bought, sold, traded or bred; exempting scientific or research premises.

House Bill 595.—Establishing a certification requirement for hearing aid dealers and setting up an Advisory Council for same.

House Bill 691.—Providing for hospital services or medical treatment of minors without parental consent when they believe themselves to have, or do have venereal disease; or believe themselves to be, or are pregnant.

House Bill 712.—Providing for regulation of pharmacies and defining "pharmacy."

House Bill 736.—Redefining the definition of Physical Therapy.

House Bill 743.—Excluding the Sheriff of Baltimore County from the responsibility of ensuring physicians are registered in the County Clerk's office.

House Bill 746.—Requiring the State Board of Health and Mental Hygiene to supply psychiatric examination and treatment for emotionally disturbed students.

House Bill 747.—Providing the school system to perform psychological testing of children when indicated.

House Bill 765.—Requiring notification of Department of Motor Vehicles of drivers convicted of driving under the influence of narcotics.

House Bill 766.—Changing provision for licensing of physicians by making reciprocity mandatory instead of permissive.

House Bill 796.—Repealing bond authorization of $3,000,000 for Baltimore City to build a central health and morgue building.

House Bill 874.—Establishing a provision for Physical Therapist apprentices.

House Bill 901.—Transferring the functions of the Air Pollution Control Council to the State Department of Health.

House Bill 935.—Requiring members of volunteer ambulance and rescue squads to complete Red Cross or First Aid courses in order to be exempt from prosecution under the Good Samaritan Law.

House Bill 945.—Establishing a licensing law for ambulances.

House Bill 947.—Revising laws on emergency admissions of mentally ill persons to mental health facilities.

House Bill 955.—Providing for extension of deadline for construction of outpatient buildings at University of Maryland Medical School.

House Bill 957.—Repeal of Charles County bond authorization for erection of a new hospital.

House Bill 962.—Permitting State Board of Health and Mental Hygiene to appoint staff and exempting them from the provisions of the Standard Salary Board.

House Bill 1034.—Clarifying certain exemptions under barbital and hypnotic drug laws.

House Bill 1037.—Restricting the subrogation rights of insurance carriers and hospital and medical service corporation.

House Bill 1051.—Providing for a premarital STS.

House Bill 1068.—Providing that physical examinations for work permits for minors may be performed by any licensed physician.

House Bill 1070.—Changing the composition of the State Board of Health and Mental Hygiene by adding the Commissioner of Health and the Commissioner of Mental Hygiene and having them designated as Chairman and Vice-Chairman by the Governor; and changing the responsibilities of the Board.

House Bill 1103.—Providing for a change in the dental laws.

HOUSE RESOLUTIONS

No. 48.—Proposing Study Group to consider problem of alcoholism in Maryland and make recommendations as to possible solutions.

No. 75.—Requesting Department of Health to investigate question of standards set for mobile vendors of "soft ice cream" and "snowballs" in State.

No. 79.—Relating to improprieties of certain insurance companies providing hospital insurance to persons 65 and older.

SENATE BILLS

Senate Bill 21.—This bill would permit the Mental Hygiene Commissioner to designate any psychiatrist in the Department of Mental Hygiene to conduct sanity examinations authorized by law.

Senate Bill 75.—Revision of the Dental Laws, providing for notification by dentists of address changes, among other things.

Senate Bill 105.—Implied Consent law; providing for the taking of an alcohol test or face license revocation.

Senate Bill 127.—Restricting the sale, possession, manufacture or use of LSD, unless by physicians in the case of scientific use or research.

Senate Bill 130.—Increasing the number of medical school scholarships from 10 to 20, with such scholarships being repaid by practice in areas declared to be in need of a physician.

Senate Bill 134.—Implied Consent (See Senate Bill 105).

Senate Bill 181.—Exempting physicians to whom patients may be referred for laboratory tests from permit requirements; also to exempt hospital laboratories from the same requirement if supervised by a physician.

Senate Bill 197.—Providing for nursing scholarships.

Senate Bill 203.—Permitting Osteopaths to practice medicine and surgery.

Senate Bill 283.—Defining the term "pharmacy" and authorizing issuance of rules and regulations.

Senate Bill 284.—Specifying what type of advertising may be done by a Pharmacy.

Senate Bill 290.—Amending the definition of Podiatry.

Senate Bill 315.—Providing for examinations of minors without parental consent who have or suspect they have venereal disease or are or suspect themselves to be pregnant.

Senate Bill 325.—Implied Consent law (See Senate Bill 105).

Senate Bill 342.—Providing for inspection without a warrant of premises on which 25 or more dogs are kept—exempts scientific or research premises.

Senate Bill 354.—Abolishing the Air Pollution Advisory Council and transferring these responsibilities to the State Department of Health.

Senate Bill 357.—Changing the compensation of members of Board of Physical Therapy Examiners.

Senate Bill 359.—Work permits for minors, removing legal requirement that they be issued only by "designated physicians," and substituting the issuing authority as the county school superintendent; after physical examination by a duly licensed physician.

Senate Bill 363.—Establishing a Governor's inter-departmental Commission and Advisory Council on Handicapped.

Senate Bill 381.—Increasing the tax on alcoholic beverages, revenue from which would be used to establish an Alcoholics' Rehabilitation Fund to be administered by Commissioner of Mental Hygiene.

Senate Bill 390.—Increasing the state debt and loan fund for non-profit hospitals.

Senate Bill 391.—Abolishing Advisory Council on Hospital Licensing and Advisory Council on Hospital Construction; and establishing an Advisory Council on Medical Facilities Construction and Licensing.

Senate Bill 410.—Providing for state subdivisions to pay 20% of hospital costs for medical care program patients from their subdivision.

Senate Bill 457.—Amending the law to exclude from *any* school in Maryland any worker with communicable tuberculosis.

Senate Bill 458.—Establishing authority for licensing users of ionizing radiation.

Senate Bill 459.—Amending the Laboratory law to permit advertising by any laboratory.

Senate Bill 474.—Permitting hospitals to notify parents to have infant tested for PKU after discharge from hospital, if such has not been done while infant was in hospital.

Senate Bill 482.—Amending the law to provide for $20,000,000 additional loan funds for voluntary, non-profit hospitals.

Senate Bill 486.—Amending the medical care law to provide for payment for Optometrists' services.

Senate Bill 508.—Repealing law that provided for bond authorization of $3,000,000 for a Central Health and Morgue Building in Baltimore City.

Senate Bill 512.—Amending the Chiropractic Law to provide for licensure without examination, if certified by the National Chiropractic Examining Board.

Senate Bill 513.—Allowing Chiropractors to be compensated under commercial insurance policies.

Senate Bill 565.—Providing for emergency admission of persons to mental health facilities.

Senate Bill 577.—Including pharmacy services in non-profit health service plans.

Senate Bill 596.—Authorizing the Department of Motor Vehicles to undertake a study of emergency medical facilities in Maryland.

Senate Bill 601.—Authorizing the Department of Motor Vehicles to establish minimum physical and mental standards for motor vehicle operators.

Senate Bill 602.—Authorizing the Department of Motor Vehicles to define physical or mental disorders that may prevent a person from exercising reasonable control over a motor vehicle, and requiring reporting of such by physicians.

Senate Bill 603.—Providing for a medical examination of a motor vehicle operator who has two convictions of drunken driving.

Senate Bill 665.—Establishing a center and hospital for psychiatric research.

Senate Bill 673.—Providing an alternative method by which the Department of Mental Hygiene may investigate and determine the financial conditions and eligibility of patients.

Senate Bill 675.—Changing the abortion law by defining when abortions may be performed legally (more restrictive.)

Senate Bill 676.—Providing that abortions may be performed only when the patient has been a resident of Maryland for one year prior to the abortion.

Senate Bill 677.—Creating the position of Deputy Commissioner of Mental Hygiene.

Senate Bill 694.—Defining child care centers and providing procedure for 50% of the cost of reimbursement by State of hospitals operating child care centers.

SENATE RESOLUTIONS

No. 8.—Requested implementation of law providing that narcotic addicts may be committed to an institution or hospital for treatment rather than sentenced to jail.

JOINT RESOLUTIONS

Senate 10.—Requested State Board of Health and Mental Hygiene to make a study of the feasibility of establishing requirements for food handlers' permits.

Senate 36.—Requested Legislative Council to consider feasibility of combining the Departments of Health, Welfare, and Mental Health into one department.

Senate 32 and House 34.—Requested Governor to appoint Commission to study guardianship problem posed by mentally retarded and handicapped and State's role therein.

Senate 55.—Urged Governor to request from Legislature in supplemental budget, $433,000 to complete funds necessary to build proposed new Medical Examiner's Facility in Baltimore City.

House 3.—Requested Governor to establish coordinating committee of State agencies concerned with education and rehabilitation of handicapped children in Maryland.

House 4.—Requested Governor to appoint Commission to continue and extend the work of 1966 Governor's Commission to Study Education Needs of Handicapped Children.

House 14.—Requested Governor to appoint Commission to study establishment of recreational centers for persons discharged or on leave or paroled from mental institutions.

House 45.—Requested Governor to appoint Study Group to examine feasibility of establishing subsidies for interns and residents in hospitals in Maryland to relieve shortage of interns and residents.

House 67.—Promote awareness of objectives and findings of Workshop and Rehabilitation Facility Planning currently conducted by Division of Vocational Rehabilitation of State Department of Education in cooperation with other State and community rehabilitation oriented organizations.

Respectfully submitted,
B. Martin Middleton, MD, Chairman
Benjamin S. Crosby, Jr., DDS
I. Rivers Hanson, MD
Karl F. Mech, MD
Belden R. Reap, MD, LLB

LIAISON COMMITTEE

Mr. President and Members of the House of Delegates:

Two meetings of the full Committee were held during the past year, in addition to which the Subcommittee on Pharmacy held two lengthy sessions.

In connection with liaison with state agencies concerning the shortage of general practitioners, it was announced that ten Senatorial Scholarships had been awarded for 1966-67 from twenty-two applications. The State Health Department in conjunction with the Medical and Chirurgical Faculty will determine the areas of need in the State, where these scholarship winners will be designated to practice as a condition of their awards.

It was also announced that a compendium of laws, rules, and regulations with which physicians must comply has been compiled and distributed to the membership.

Physical examinations for school bus drivers were under study with the Faculty expressing concern over certain areas of the form required by the State Superintendent of Transportation.

Other matters which came up for discussion included work permits for minors; drug discounts for Medical Care patients; nurses' responsibility in dispensing drugs and also interpreting EKGs in coronary care units; screening and revising of all State Health Department, insurance, and laboratory forms; as well as the communicable disease reporting form.

The Pharmacy Liaison Subcommittee voted to adopt a formal position in opposition to the compulsory use of generic drugs in any federal or state medical care program, and also resolved to recommend to the Liaison Committee that it oppose any attempt to establish a formulary system for any medical care program in Maryland.

In connection with volume discounting, the Subcommittee then voted: 1) that the Pharmaceutical Manufacturers Association be contacted with a view to striving for continued reduction in drug prices, and that as more and more third party payments for drug expenses occur, continued pressures will be exerted for the reduction of drug prices; 2) to bring to the attention of the Occupational Health Committee that many industrial clinics are either intentionally or unintentionally providing drugs at wholesale cost to employees which may be in violation of the State's drug laws; 3) to refer to the Liaison Committee the question of whether or not the Faculty should adopt a position on the matter of volume discounts offered to the State Health Department in operation of Medical Care programs.

The new chairman of the Medicine and Religion Subcommittee attended a workshop conference in Chicago from which much information was gained.

Both the Faculty and the Maryland Pharmaceutical Association went on record as being opposed to the abolition of the Council on Medical Care of the State.

Respectfully submitted,
William L. Stewart, MD, Chairman
Aris T. Allen, MD
Melvin N. Borden, MD
Robert E. Farber, MD
Paul F. Guerin, MD
Claude D. Hill, MD
Elmer N. Hoffman, DDS
Walter E. James, MD
W. Kenneth Mansfield, MD
William J. Peeples, MD
Aaron H. Traum, MD
H. Leonard Warres, MD

PHARMACY LIAISON SUBCOMMITTEE: Melvin N. Borden, MD, Chairman; John F. Schaefer, MD, Edgard P. Williamson, MD, Mr. Nathan I. Gruz, Mr. Wilford H. Gluckstern, Mr. Victor H. Morgenroth, Jr., Mr. Morris R. Yaffe.

SUBCOMMITTEE ON RADIOLOGY SERVICES: H. Leonard Warres, MD, Chairman

SUBCOMMITTEE ON MEDICINE AND RELIGION: Donald W. Mintzer, MD, Chairman; James G. Arnold, MD, Frederick D. Dove, Jr., MD, I. Bradshaw Higgins, MD, Harry L. Knipp, MD, Louis Krause, MD, Karl F. Mech, MD, Sidney J. Venable, MD, Frederick J. Vollmer, MD, Joseph B. Workman, MD.

LIBRARY AND HISTORY COMMITTEE
FINNEY FUND COMMITTEE

Mr. President and Members of the House of Delegates:

During 1966 several projects were considered by the Library Committee, namely the engagement of a library consultant who is a specialist in rare book collections, and, the possibility of securing a construction grant for an addition to the present building. This would increase the library stack capacity, provide a rare book room and history of medicine section, and include a museum. As of the end of the year Mr. Lee Ash, New Haven, Connecticut, had been secured to visit the library in January to make a preliminary survey of the collection and estimate the cost of completing the job.

In May Mrs. Gloria Miller resigned to take a position with Baetjer Memorial Library at The Johns Hopkins Hospital. Since that time we employed a librarian from the Baltimore City School System, Miss Sarah Katzoff, as cataloger during the summer, and Mrs. Raquel Cabanilla from Manila, cataloger, during the fall. Mrs. Vera Anderson started as part-time clerical assistant in May. The position of assistant librarian remains unfilled.

The staff situation at year's end was as follows: One professional librarian; one clerical assistant, part-time, working three days a week, two part-time student assistants, and a maid who also assists with shelving and processing books and journals. One professional librarian is available for substitute and "extra" work on a very limited basis. The final analysis shows one full time librarian and the remainder of the staff part-time.

As many visits to county meetings have been made as time, weather, and staff permitted. It is hoped that these can be increased when the staff is back to normal. Books are taken to the meetings for charge-out and requests for special subjects, bibliographies, and books are received for subsequent filling.

The library became the recipient of an additional source of income for books and journals from the estate of Walter Ralph Steiner, MD, on the death of Amy L. Steiner, his sister and sole remaining beneficiary of his trust. This generous bequest will enable the library to purchase a considerable number of publications not now in our collection.

The usual outside activities of the library continued with the two-day regional meeting of the Medical Library Association in Baltimore in October, featuring courses in continuing education and prominent guest speakers from this area as well as Virginia and D.C. Mrs. Sanford attended the Advisory Council of Special Libraries Association Meeting in Albuquerque, representing the SLA Baltimore Chapter, the annual meeting of SLA in Minneapolis and the annual meeting of the Medical Library Association in Boston.

The library received the sum of $800 for a duplicate set of the Surgeon General's Catalogue during the year from Swets and Zeitlinger, Berwyn, Pa.

Statistics for the year 1966 are as follows:

Circulation	
Books	1,641
Journals	3,723
Vertical File (Pamphlets)	200
Total	5,564
Gifts (Books & Journals)	933
Xeroxing (pages)	6,311
Bibliographies	170
Volumes added:	
Journals	374
Books	430
Total volumes	804
Total volumes	93,136
Attendance	2,441

Respectfully submitted,
Library and History Committee
Louis Krause, MD, Chairman
H. Baldwin Street, DDS
Katharine A. Chapman, MD
Robert B. Goldstein, MD
Paul F. Guerin, MD
Thomas C. Hill, MD
Finney Fund Committee
D. C. W. Finney, MD, Chairman
Richard G. Coblentz, MD
Richard W. TeLinde, MD
Richard V. Hauver, MD
John P. Haberlin, MD

MARYLAND MEDICAL SERVICE, INC.
BOARD OF TRUSTEES

Mr. President and Members of the House of Delegates:

Substantial increases in all areas of the Plan's operations were realized in 1966, along with the assumption of major new responsibilities in the administration of the Medicare program.

Despite the loss of some 32,000 members through the cancellation of a large group of employees of the State of Maryland, whose coverage was awarded to a commercial insurance company, enrollment increased by more than 56,400 (6.3%) during the year. At the end of the year, total membership of 946,000 was equivalent to 80.5% of that of our companion Blue Cross Plan. Group enrollment accounted for 80% of our membership, and there was heavy shifting from standard to special coverage and from Plan A to Plan B throughout the year. Much of the increase in direct enrollment was concentrated in the Blue Shield 65 program which was purchased heavily by Medicare-eligible Marylanders last spring.

Financially, the Plan operated on just about a break-even basis, experiencing a small underwriting gain of $40,000 (0.2%) during the year, as compared with a loss of over $226,000 (1.4%) in 1965. Earned subscription income reached a new high of $18,500,000 in 1966, up about $1.7 million from 1965. Incurred claims also reached a new high, $16.7 million, about $1,000,000 more than in the previous year. Operating expenses during the year rose from 35.2¢ to 36.2¢ per contract per month, an increase of 2.7%.

The volume of processed claims increased steadily in 1966, over 400,000 having been paid in the twelve-month period for an average of about 7,900 per week. Of these, 191,673 were of a surgical nature (with 119,673 having been provided in physicians' offices or hospital outpatient departments), 47,288 were medical in nature, 13,524 obstetrical, 51,653 anesthesiological, 32,175 pathological, and 57,953 radiological. Professional anesthesiology was provided in 61.6% of the inpatient surgical and obstetrical cases, and of the 10,863 consultations covered, 33.3% were of the multisystem nature.

During 1966, the number of participating physicians rose to 3,450 from 3,338 at the beginning of the year. This represents 92% of the physicians who provided services to Maryland Blue Shield subscribers during the year.

A reasonable and customary fees program was developed and filed with the Insurance Department in 1966, and although formal approval had not been received at year's end, it is our understanding that only some minor adjustments in contract language need to be worked out. The sale of this program in coming years should fill a growing need among our large group accounts and should receive enthusiastic acceptance by Maryland physicians.

Undoubtedly, our most time-consuming activity during the year was planning for and beginning the administration of the Medicare Part B program. After a relatively slow beginning, claims activity under this program mushroomed in the last three months of the year. At the end of the year claims were being received at the rate of 1,000 per day and, despite a doubling in staff and a great deal of overtime work, a substantial backlog had built up. By mid-February we had succeeded in reversing the trend, however, and as of this writing, a major reduction in the claims inventory has been accomplished. By early Spring, an average claims payment cycle of about three weeks should be established.

In closing, I wish to express my appreciation for the advice and counsel of the Blue Shield Board of Trustees and the members of the Reference and Appeals and Medical Relations Committees, all of whom have been most faithful in carrying out their responsibilities. To the staff of Blue Shield, who have given so unstintingly of their skills and time, much of it personal, are extended the thanks of all the Trustees.

Respectfully submitted,
J. Sheldon Eastland, MD, President
Maryland Medical Service, Inc.

MARYLAND STATE MEDICAL JOURNAL

Mr. President and Members of the House of Delegates:

The financial report for 1966 is as follows:

Cash income received from Journal advertising, subscriptions, and other sources	$86,660.89
Cost of publishing Journal, including salaries, etc., (exclusive of light, heat, office space)	$93,106.61
Expenses over income	$ 6,445.72

The figure shown is not a true deficit, however, as the cost of publishing the transactions of the House of Delegates and the Membership Directory are charged to the Journal. In addition, the Journal office turned over to the library many books sent for review. In any event, the financial picture of the Journal has improved over last year as the deficit for 1966 is approximately half of what it was in 1965. This is due, for the most part, to an increase in advertising over the past year.

During 1966, George H. Yeager, MD, resigned as editor of the Journal. Dr. Yeager had served as editor since the inception of the Journal and it was with sincere regret that his resignation was accepted. Mrs. Doris E. Fletcher, who had been managing editor for a number of years, also resigned, to accept another position.

Richard L. Masland, MD, and Moses Paulson, MD, accepted positions on the editorial board replacing Henry P. Laughlin, MD, and Louis R. Schoolman, MD, whose terms had expired. Our appreciation is extended to Drs. Laughlin and Schoolman for their valuable assistance in the past.

Although several personnel changes have taken place during the past year, there is no anticipated change in the editorial policy of the Journal.

In the past there had been a backlog of manuscripts, but this is no longer true. In fact, there is an acute shortage of scientific papers available for publication. Papers presented at several medical society meetings have been transcribed for use in the Journal and letters have been sent to many physicians and hospitals asking that they consider submitting material for publication. It is the desire of the editor and the editorial board to enlist the support of the members of the House of Delegates in assisting us to secure manuscripts for the Journal.

Respectfully submitted,
C. Thomas Flotte, MD, Editor
Alice W. Kellogg, Managing Editor
Editorial Board:
Leon W. Berube, MD
Houston S. Everett, MD
E. T. Lisansky, MD
Richard L. Masland, MD
Moses Paulson, MD
Edward C. H. Schmidt, MD

MEDIATION COMMITTEE

Mr. President and Members of the House of Delegates:

The Mediation Committee has met almost monthly during the past year. The number of questions raised by members, organizations and others continues to increase.

An Ethics Seminar was held on October 15, 1966, at which attendance was not all that could be desired. The proceedings were published in a subsequent issue of the Maryland State Medical Journal.

The most serious matter to come before this Committee during the year was a physician who was involved in obtaining "kickbacks" from a dispensing optician. This is in violation of Federal Trade Commission Rule #7. Once this was brought to the attention of the physician concerned, the practice was halted and on a recent check it was learned that it has not been resumed.

In appropriate cases, matters were referred to the Board of Medical Examiners for its consideration.

The Committee is in accord with the proposed changes in the Medical Practice Act, to provide for a Commission on Medical Discipline and specifying certain acts that would be unethical or illegal if committed by physicians.

A list of cases handled by Component Societies and those handled on a state level because the physician was a non-member of the component or by referral from a local level is depicted in the following chart.

	Mediation Cases 1966 Total	Cases for Complainant	Cases for Defendant	Cases Pending at 12/31/66	Cases Settled Mutually	No Action	Cases referred to Components	Referred to Board Medical Examiners	Reprimanded
Allegany County	0								
Anne Arundel County	0								
Baltimore City	37	4	18	2	13				
Baltimore County	9		8	1					
Calvert County	1			1					
Caroline County	0								
Carroll County	0								
Cecil County	1	0	1	0					
Charles County	0								
Dorchester County	0								
Frederick County	0								
Garrett County	0								
Harford County	0								
Howard County	0								
Kent County	0								
Montgomery County	28	2	17	6	3				
Prince George's County	17	3	8	2	4				
Queen Anne's County	0								
St. Mary's County	0								
Somerset County	0								
Talbot County	0								
Washington County	5	1	3	1					
Wicomico County	2	1	1	0					
Worcester County	0								
CASES HANDLED ON STATE LEVEL	7	1	4	2	0		7	6	

Respectfully submitted,
Wolcott L. Etienne, MD, Chairman
M. McKendree Boyer, MD
Robert vL. Campbell, MD
John T. Chissell, MD
John M. Dennis, MD
J. Sheldon Eastland, MD
Russell S. Fisher, MD
Robert B. Goldstein, MD
Lewis P. Gundry, MD
Conrad L. Inman, Jr., DDS
Howard F. Kinnamon, MD
Louis J. Kolodner, MD
Charles F. O'Donnell, MD
John F. Schaefer, MD

MED-CHI INSURANCE TRUST

Mr. President and Members of the House of Delegates:

The Med-Chi Insurance Trustees have met almost every month since the Trust was organized in 1965 in an effort to increase the scope and efficiency of existing programs and to study the feasibility of new programs. Several of these meetings were attended by representatives of insurance companies, as well as, subscribers with insurance problems. The Trust now administers the following programs: (1) Health and Accident Insurance; (2) Major Medical and Accidental Death Insurance; (3) Blue Cross and Blue Shield; (4) Business Expense Disability Insurance; and (5) Life Insurance. As a result of a poll of members of the Medical and Chirurgical Faculty, additional types of programs are being investigated including liability insurance and a retirement program.

Beginning January 1, 1968, there will be a liberalization of regulations concerning tax free pension contributions for self employed individuals. By request of the Council, the Trustees are investigating various types of retirement plans and intend to initiate a retirement program prior to the expiration of this year.

All administrative functions for these programs are now centralized in the Trust office located in the Faculty building. This has resulted in an increased efficiency in the management of the programs, as well as, an increased convenience to subscribers or potential subscribers in obtaining information about insurance matters.

As each new program is developed, as far as possible, the following general policies will be followed:

(1) Bills for premiums, claims processing, processing of new applications, and the distribution of promotional material will be handled by the Central office.
(2) A written agreement will be obtained with each insurance company requiring an annual report to the Board of Trustees as well as specifications relative to the adjustment of premiums in relation to the experience of the program.
(3) Each new program will be reviewed by a consulting actuary in an effort to promote only financially sound and economical programs for the members of the Faculty.

We trust that these policies will result in a broad spectrum of good programs efficiently administered and enthusiastically supported by the membership.

Respectfully submitted,
Paul F. Guerin, MD, Chairman
Harry J. Connolly, MD
William J. McClafferty, MD
Alfred S. Norton, MD
Edwin R. Ruzicka, MD
Richard A. Young, MD

MEDICAL ADVISORY COMMITTEE OF THE RED CROSS BLOOD BANK PROGRAM

Mr. President and Members of the House of Delegates:

The Baltimore Regional Blood Program of the American Red Cross operates as one of 55 blood centers throughout the country under the United States License No. 190 of the National Institutes of Health. It is a national voluntary blood donor service which produces one-half of the blood used in the United States. The Baltimore program was established in December 1958, to supplement the collections of the 32 hospital blood banks operating in the Baltimore area. The Red Cross now provides more than 44% of the whole blood used by these hospitals. In addition, the program is rapidly approaching a total supply of certain important blood derivatives.

The Baltimore Regional Chapter Program is and has been the largest single program in the Baltimore area and is the community's most significant voluntary donor program. It contributes more than any agency or group of agencies toward an adequate community supply of blood.

More than 800,000 individuals are protected by the Baltimore Regional Program, and this number continues to grow. Both group and individual plans of coverage are offered, making it possible for anyone in the community to participate and receive protection. The Red Cross has concentrated its efforts on the group donor coverage with only limited emphasis on the individual coverage. At the present time the total blood needs of the Baltimore area are estimated at approximately 72 thousand units per year.

The Baltimore program was originally established to supplement the hospital blood banks' supply by replacing the blood used for Red Cross eligibles. However, with the introduction of the revolving credit system, sufficient flexibility has been developed so that the Red Cross now distributes blood in advance of credits, which is used by the hospitals as needed for any patient. Accordingly, when the Red Cross advances blood to a hospital, it is considered the property of that hospital to be used as needed with the understanding that the hospital take steps to balance the credits used by Red Cross eligibles with the total amount advanced to the hospital.

The Red Cross does not transfuse any blood. It is the aim of the Red Cross, in partnership with the hospital blood banks, to obtain the total amount of blood needed.

The Red Cross also assists hospitals in supplying blood, as available, for community needs, including lifesaving emergencies, blood for leukemia and hemophilia patients, and blood for indigents.

All Red Cross blood which is not distributed for transfusion is processed into important derivatives. From December 1, 1958 to December 1, 1966, the 32 participating hospitals received the following:

191,456—units refrigerated whole blood
876—units serum albumin (5%)
4,644—units fresh frozen plasma
795—20 cc units serum albumin
3,643—100 cc units serum albumin
3,491—units gamma globulin
345—units fibrinogen
1,664—units packed red cells
37,576—units gamma globulin were also distributed through the Maryland State Department of Health.

Of the 191,456 units of refrigerated whole blood, 19,711 units were donated to the hospitals to assist those blood indigents who could not replace their own blood or were not able to shoulder the financial burden. From the PULSE refrigerator an additional 8,076 units were rushed to the hospitals to help save the lives of 1,742 patients who needed blood because of an unexpected bleeding emergency.

(Continued)

Linda, MU. 5-3000



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the Lucas Design Group was made up of men only. But now we've added the feminine touch to our knowledgeable staff. Her name is Linda Watkins. And like the proficient men in the LDG Group, she's an expert in solving office space problems . . . a specialist in planning and providing distinctive office furnishings. If you're deciding to dress-up your offices, phone Linda at MU 5-3000. Believe us, she's as talented as she is well designed!

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Tandearil®
oxyphenbutazone

Tandearil in Painful Shoulder

Therapeutic Effects: Stiffness and pain may diminish within 2 days, and full mobility may be restored within a week. These effects are obtained with oxyphenbutazone alone or combined with physiotherapy or local hormonal injections. The drug is usually well tolerated and does not affect pituitary-adrenal function or immune response.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Painful Shoulder: 600 mg. daily in divided doses for 2 to 3 days; 300 mg. daily thereafter. Usual duration of therapy: 2 to 7 days.

Availability: Tablets of 100 mg. 6562-VI(B)R

For complete details, please refer to full prescribing information.

Geigy
Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

Geigy

Tandearil® oxyphenbutazone helps painful shoulders move again



3 out of 4 painful shoulder patients responded well

84.2% of 127 patients

81% of 48 patients

Please see adjoining page for brief prescribing summary.

TA-5094PC

Sperling, I. L. Applied Therap. 6 117, 1964.
Rosenbaum, E. E., and Schwarz, G. R. Northwest Med. 61:927, 1962.

Why these 7 patients with moderate to severe anxiety may respond better to Mellaril

1. The agitated patient.
Anxiety—particularly that beyond the range of minor tranquilizers—frequently is expressed as gross motor restlessness, fidgetiness and purposeless movements, and may erupt into aggressive behavior. Mellaril is almost a specific for those patients whose anxiety follows such a pattern.





The psychosomatic patient.
The family physician is rarely given the agnostic luxury of a classic, textbook "anxiety state." Most often he must probe for anxiety masked by dysfunctional disorder—or which exacerbates a somatic problem. Double-blind evaluations have demonstrated that Mellaril can be a significant adjunct in the treatment of such patients.



The patient under situational stress.
Mellaril helps the patient deal with stress of everyday life. Nonhabituating, it can be given for extended periods of time. It does not "separate" patient from practical problems or pressures, does not induce euphoria or fuzziness which can compromise the ability to cope with reality. Rather, it helps the patient move more competently in his daily world by eliminating useless tension, by allowing him to conserve emotional resources and energies, and to direct them against the problems really worth worrying about.



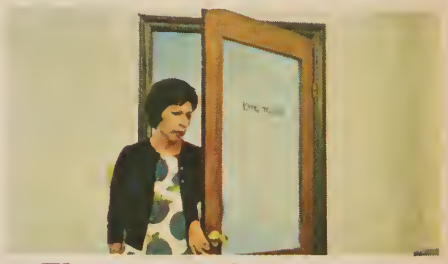
4. The menopausal patient.
The woman who sees change of life as the end of useful life requires support from both family and family physician. Whether the psychological impact of menopause is directly related to hormonal changes, or merely coincidental, is debatable, but estrogenic therapy is frequently inadequate. Mellaril is a useful aid for these patients and, alone, or in combination with reduced estrogen dosage, will help ease the menopausal misery.



5. The previously hospitalized psychiatric patient.
Such a patient may still require the type of medication he has been accustomed to, but because he is no longer in a controlled setting the acceptable level of adverse reactions must be lower. In such circumstances Mellaril is perhaps the drug of choice.



6. The agitated geriatric.
Tranquilizer therapy in the elderly patient always involves special (or at least accentuated) problems: the possibility of drug-induced ataxia, hypotension or depression, for example, assumes an additional significance. These reactions have rarely been observed in geriatric patients treated with Mellaril.



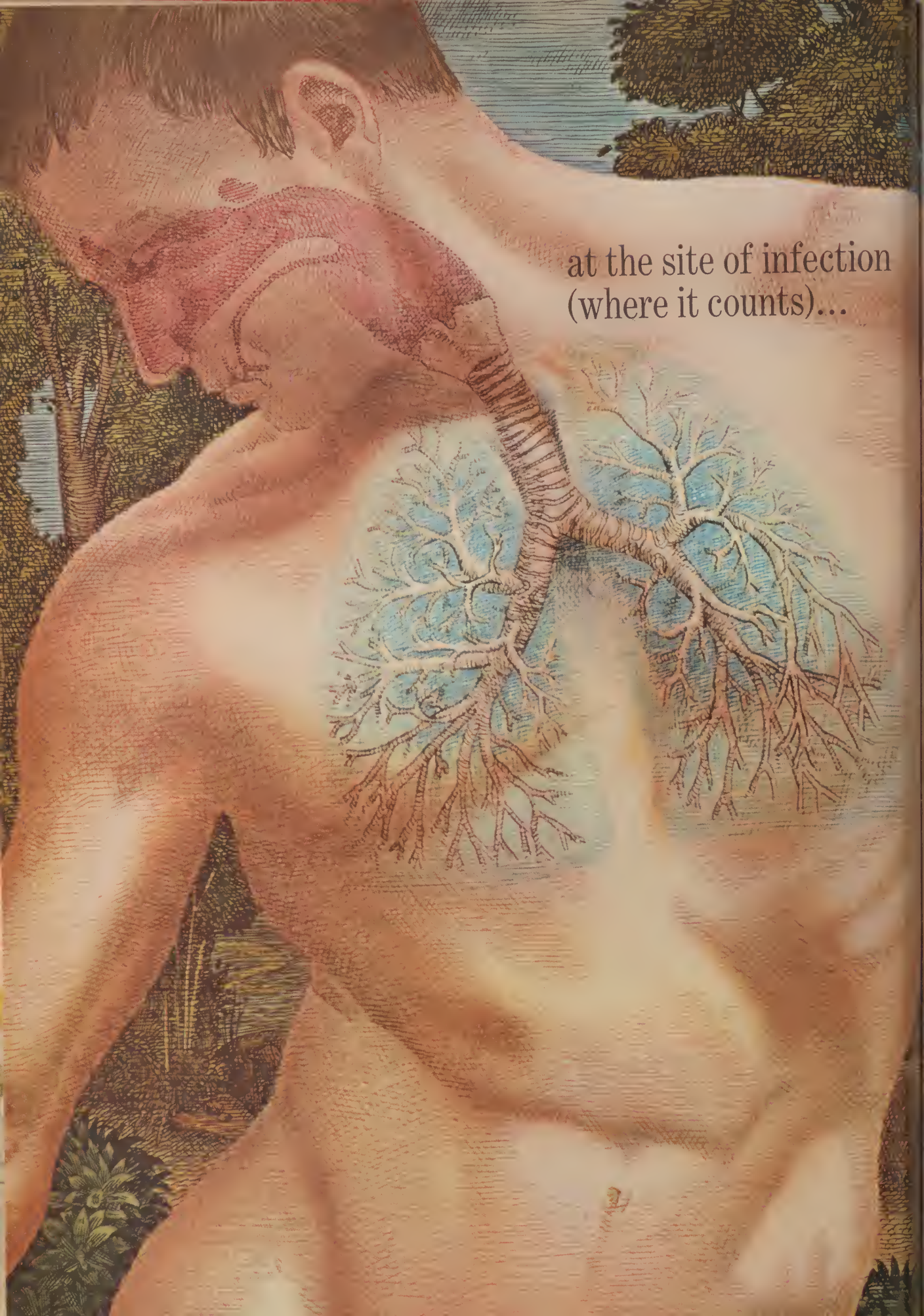
7. The constantly returning patient.
The anxiety patient who has not responded to a minor tranquilizer is not very likely to benefit from your minor tranquilizer of second choice. A major tranquilizer, such as Mellaril, may be indicated in such patients.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.
Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.
Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.
Before prescribing, see package insert for full product information.

in moderate to severe anxiety, 25 mg. t.i.d.

Mellaril®
(thioridazine)

SANDOZ


at the site of infection
(where it counts)...

Ilosone® provides more antibacterial activity than any other oral erythromycin

Acid stable, better absorbed ... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food[1-3]

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

700121

Ilosone®
Erythromycin Estolate

Lilly

(See next page for prescribing information.)

Ilosone®/the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Side-Effects: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have appeared in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly if the drug is readministered to sensitive patients, usually within forty-eight hours. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appeared to be definitely related to use of the drug, laboratory findings w characterized by increased direct-reacting bilirubin, eleva alkaline phosphatase levels, negative or weakly positive cepha flocculation and thymol turbidity tests, elevated serum gluta oxalacetic transaminase levels, peripheral eosinophilia, and n mal cholecystograms.

Individual idiosyncrasy seems evident since jaundice has b been reported in other patients taking prolonged courses of medication. Patients with chronic infection have been given 1 to 2 Gm. of the drug daily for periods of two to six months, a patients with rheumatic fever have taken prophylactic doses 0.5 Gm. daily for two years without difficulty. In one group 144 patients who received the drug daily for two years, no ja dice was noted. It was of interest that members of six of the patients' families, who were not taking the drug, had episod of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels we determined in a group of fifty-four adults and children who to 250 mg. of Ilosone daily for an average of sixteen months a rheumatic fever prophylaxis. The results were compared wi those of a similar group of forty-four patients who received pe icillin. There were no cases of jaundice in either group. Elevati of SGPT and serum alkaline phosphatase levels during the cour of treatment was observed in one patient treated with Ilosone and in two patients treated with penicillin. Seven other patien in the group receiving Ilosone and four others in the penicil group showed elevations in one of the tests at some time durin administration of the drugs.

Very satisfactory therapeutic results, without toxicity, we reported in 102 pediatric patients who received short-term (te day) courses of Ilosone in the treatment of streptococcus inf tions. Results of liver function tests in these patients were co parable to those in a similar control group who had receiv penicillin.

Gastro-intestinal disturbances not associated with hepatic fects are observed in a small proportion of individuals as a res of a local stimulating effect of the medication on the alimenta tract; however, the normal intestinal gram-negative bacter flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with the of erythromycin, there have been occasional reports of urtica skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orally.

Ilosone Pulvules®
Ilosone Chewable Tablets
Ilosone Drops
Ilosone, 125, for Oral Suspension

For infants and for children under twenty-five pounds of b weight, the usual dosage is 5 mg. per pound every six hours; f children twenty-five to fifty pounds, 125 mg. every six hou (Tablets Ilosone Chewable should be chewed or crushed a swallowed with water.)

For adults and for children over fifty pounds, the usual do of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythrom therapy should be considered.

In the treatment of syphilis, the recommended total dosag 20 to 30 Gm. given in divided doses for a period of ten to fif days. Close follow-up of the patient is necessary since eryt mycin drugs have not had adequate evaluation in all stage syphilis. Examinations of spinal fluid are recommended as p of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four days recommended. In the treatment of gonorrhea, patients wi suspected lesion of syphilis should have a dark-field examina before receiving antibiotics, and monthly serologic tests sh be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and 25 (equivalent to base), in bottles of 24 and 100.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to ba in bottles of 50.

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 1 size packages, with dropper calibrated at 25 and 50 mg.

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equiva to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size pack

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:69,
2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:39
3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198,

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.

The original agreement provided for the later development of a Lifesaving Emergency Blood Donor Corps, which would concentrate on enrolling persons of rare types and groups to further assist the hospital blood banks in meeting the general community needs. At a meeting of the Medical Advisory Steering Committee, November 13, 1963, it was considered highly desirable that the Red Cross should take steps to further expand its program to include the emergency donor corps. By so doing, the Red Cross established a separate blood inventory which is reserved for cases certified by the attending physician as being lifesaving emergencies. To make this program successful, the close cooperation of pathologists, blood technicians, and hospital administrators is essential. An effective control was established. The hospital technician is required to secure special authorization from the attending physician, which he submits in writing (within 72 hours) for review by the selected members of the Medical Advisory Committee. Replacements to the pool are made from special evening donations from members of PULSE (Public Unit for Life Saving Emergencies).

To establish the PULSE donor corps, the Red Cross Recruitment Committee and staff visited the existing blood assurance groups to enlist the support of management and the cooperation of their groups to obtain individual pledges to give blood on call. The Red Cross also invited the general public to join the emergency corps. The active support of the Baltimore Metropolitan Coordinating Blood Council, the Association of Commerce, the AFL-CIO Labor Council, and other appropriate organizations was sought. The PULSE donor corps was properly publicized to stimulate group and individual participation. All donors who are not already covered receive assurance of blood replacement for themselves and their families. The emphasis is placed on community service.

A special group of Red Cross volunteers was organized to assist in scheduling the appointments for the evening PULSE donations. All bloods collected are drawn by certified registered nurses under the supervision of a licensed physician, in accordance with the medical standards of the National Institutes of Health.

The PULSE program requires the continuing cooperation and support extended by civic leaders, the medical and hospital authorities, and the donors who are concerned with the blood needs of our community.

Respectfully submitted,
Everett S. Diggs, MD
C. Thomas Flotte, MD
Carroll L. Spurling, MD
Gerald A. Galvin, MD

MEDICAL EMERGENCY DISASTER SERVICES COMMITTEE

Mr. President and Members of the House of Delegates:

Members of the Committee attended the first annual Metropolitan Area Professions Disaster Training Seminar held September 29, 30, and October 1, 1966 in Washington, D.C. The agenda included talks by people experienced in the field on disaster training, panel discussions, movies and an actual disaster drill. The Chairman of this Committee acted as moderator for the afternoon session of the first day. Plans are presently being made for the second annual Seminar and this Committee Chairman is participating in those plans.

The Maryland Plan for Emergency Management of Resources has been approved by the Office of Emergency Planning. A copy is on file in the Faculty office. A certificate of appreciation has been received for the Chairman's participation on behalf of the MEDS Committee, signed by Director of Emergency Planning in the Executive Office of the President of the United States. A letter of appreciation was also received from Governor Tawes.

As a result of House Joint Resolution 62 approved at the 1966 session of the legislature, it was understood that a course for ambulance drivers would be added to the curriculum at the University of Maryland. However, no further details have been received.

Edward L. J. Krieg, MD, a member of the Committee, conducted two disaster drills during the past year. The first was held in November, 1966 with the cooperation of the State Health Department. A 100 bed station was set up, simulated wounded were brought in and relayed to the proper treatment areas. Radio communication was established with disaster spots, one at Montebello State Hospital and another north of the Baltimore City line. About 50 to 75 nurses, doctors, and nuns from Bon Secours, St. Agnes, St. Joseph, Women's and Union Memorial Hospitals participated. The public was invited.

A surprise drill was held in January 1967 at St. Agnes Hospital in which high school students from Cardinal Gibbons participated. The Operating Room Supervisor spent several weeks in teaching them how to simulate every kind of injury or illness. Within ten minutes of notification the entire disaster plan was put into effect and all simulated patients were put into proper treatment areas. Within two hours, the entire drill was completed and was followed by a critique held with the entire staff.

The Chairman will represent the Faculty at a Conference on Emergency Medical Services in Chicago, sponsored by the American Medical Association, on April 6, 7, 1967.

Respectfully submitted,
Charles J. Savarese, Jr., MD, Chairman
Frank E. Brumback, MD
Raymond M. Cunningham, MD
E. Roderick Shipley, MD
R. Lane Wroth, MD
Edward L. J. Krieg, MD
Kirk Moore, MD
William J. Peeples, MD
Robert J. Wilder, MD

MEDICOLEGAL COMMITTEE

Mr. President and Members of the House of Delegates:

The Medicolegal Committee and its various subcommittees held frequent sessions during the year, which were designed to achieve greater understanding and cooperation between the medical and legal professions.

Amendments to the Medicolegal Code of Cooperation were approved both by the Bar Associations and the Faculty's House of Delegates, with further study to be given certain amendments. Other topics discussed and referred to the proper subcommittees included symposia, status of proposed legislation, expert witnesses, and the necessity for specialist consultants in hospitals over weekends.

The Symposia Management Subcommittee held a symposium in December titled "Medical Tests Exposed in Court." Subject matter included laboratory test interpretation, the significance of results to the physician, clinical testing for patients involving the heart, lungs, brain, etc., and interpretation of EKGs, EEGs, etc.

The Subcommittee on Court Procedures studied in detail a plan recently adopted in Nevada by the Washoe County Medical Society and Bar Association, one of the few such plans in the country in which a panel meets periodically to consider requests submitted by an attorney and client in cases involving alleged professional negligence. Opinion of most in the discussion was that physicians would be willing to serve on such a panel if its findings were binding on both parties. It was also the consensus that if the decision of the panel was that the claimant probably had a good case, an expert witness from the medical profession should be supplied. Additional information on the workability of the scheme was to be sought for a report to the full Medicolegal Committee.

The Subcommittee on Interprofessional Relations held a lengthy discussion of policy on the possible reduction of fees in Workmen's Compensation cases as proposed by an attorney. The latter, a member of a committee on the Workmen's Compensation Commission group, had questioned whether doctors were entitled to "usual and customary" fees rather than the scheduled fees presently allowed when other groups were foregoing certain rights.

In rebuttal, it was submitted that attorneys practicing in the Workmen's Compensation field suffer no fee hardship, and that doctors should be compensated at their usual, customary, and reasonable rates.

Some twenty-six cases involving disputes or inquiries between doctors and lawyers were brought before this Subcommittee at its several meetings.

A report was given on a meeting of the American Medical Association and the American Bar Association referring mainly to patient referrals.

Respectfully submitted,
Howard F. Kinnamon, MD, Chairman
Conrad Acton, MD
James G. Arnold, Jr., MD
Russell S. Fisher, MD
Robert W. Johnson, 3rd, MD
J. Elliot Levi, MD
F. Ford Loker, MD
Belden R. Reap, MD, LLB
Edwin R. Ruzicka, MD
William G. Speed, 3rd, MD
John F. Strahan, MD

INTERPROFESSIONAL RELATIONS SUBCOMMITTEE: Russell S. Fisher, MD, Robert W. Johnson, 3rd, MD, Belden R. Reap, MD, LLB, William G. Speed, 3rd, MD.

SUBCOMMITTEE ON COURT PROCEDURES: Conrad Acton, MD, John F. Strahan, MD, F. Ford Loker, MD.

SYMPOSIA MANAGEMENT SUBCOMMITTEE: James G. Arnold, Jr., MD, J. Elliot Levi, MD, Edwin R. Ruzicka, MD.

MEMBERSHIP COMMITTEE

Mr. President and Members of the House of Delegates:

The Membership Committee appropriately continued to discuss guidelines for attracting new members. As a point of information, the question was discussed of what percentage of licensed physicians in the State are covered by the membership rolls of 3,502 Active and 327 Associate and Affiliates (as of May, 1966). This matter will be better determined when Baltimore City completes its compilation of membership figures.

It was recommended to the Executive Committee, after lengthy discussion, that conditions of physician's defense for Associate members remain as presently spelled out in the Bylaws: i.e. available to Associate as well as Active members. This was felt to be a strong factor in attracting and retaining Associate members.

The membership booklet to be given new members is to be revised and up-dated, and will be included with the Compendium on Rules and Regulations of the State for Physicians as presentations to new members.

Under other discussions of recruitment of new members, an effort was initiated to interest more psychiatrists in taking an active part in the activities of the Faculty through membership.

Respectfully submitted,
Nathan E. Needle, MD, Chairman
Samuel Borssuck, MD
Edward Davens, MD
William G. Helfrich, MD
Frank L. Iber, MD
Frank T. Kasik, Jr., MD
Wallace H. Sadowsky, MD
Emmanuel Schimunek, MD
Moses S. Shiling, MD
Raymond M. Yow, MD
H. David Kerr, MD
William B. Weglecki, MD

NOMINATING COMMITTEE

Mr. President and Members of the House of Delegates:

(Those elected will assume office at conclusion of the Annual Meeting 1968, unless otherwise indicated.)

For Presentation to the House of Delegates, April 1967

President-elect

Arthur G. Siwinski, Baltimore
(President-elect 1967-68)
(President 1968-69)

First Vice-President

Henry A. Briele, Salisbury

Second Vice-President

Wolcott L. Etienne, College Park

Third Vice-President

George O. Eaton, Baltimore

Secretary

William A. Pillsbury, Timonium

Treasurer

Karl F. Mech, Baltimore

Councilors

John M. Dennis, Baltimore, Central District (1971)
Harry M. Robinson, Jr., Baltimore, Central District (1971)
Donald J. Roop, Baltimore, Central District (1971)
Raymond M. Yow, Salisbury, Eastern District (1971)
J. Parran Jarboe, La Plata, Southern District (1971)

Delegates to American Medical Association

J. Sheldon Eastland, Baltimore
(Jan. 1, 1968-Dec. 31, 1970)

Alternate Delegate to American Medical Association

Robert C. Kimberly, Baltimore
(Jan. 1, 1968-Dec. 31, 1970)

Committee on Program and Arrangements

John B. De Hoff, Baltimore (1972)

Library and History Committee

Robert B. Goldstein, Baltimore (1973)

Finney Fund Committee

Richard W. TeLinde, Baltimore, (1973)

Board of Medical Examiners

John H. Hornbaker, Hagerstown (June 1967-June 1971)
Frank K. Morris, Baltimore (June 1967-June 1971)

Respectfully submitted,
Robert vL. Campbell, Chairman, Hagerstown
Arthur T. Keefe, Jr., Eastern District, Chestertown
J. Parran Jarboe, Southern District, La Plata
A. Talbott Brice, Western District, Jefferson
John T. Lynn, South Central District, Hyattsville
Margaret L. Sherrard, Central District Baltimore
John F. Schaefer, At Large, Baltimore

OCCUPATIONAL HEALTH COMMITTEE

Mr. President and Members of the House of Delegates:

The Occupational Health Committee at its several meetings discussed the status of a group known as Executive Health Examiners, whose ethics had been questioned. This group, which conducts physical examinations for executives in some 300 cities in the United States, had run into difficulties with other state medical groups bringing about unanswered questions about the group's activities in Maryland. Further information was sought from New York and Washington, D.C. to determine the Examiners' status at this time.

This Committee was asked to consider the selection of a nominee for the Governor's Award to a Physician For Promotion of Employment of the Physically Handicapped, for 1967.

A State Public Health Nursing Consultant in Occupational Health presented a lengthy program on Industrial Nursing Responsibilities. Concern for the one-nurse unit was expressed since these nurses do not get the direct physician supervision considered necessary. It was reported that industry is presently using licensed practical nurses and first aid people to replace or supplement the nursing personnel. A registry of nurses has been set up so that available nurses for relief work can be contacted. Since 1960, the number of industrial nurses in Maryland has risen to more than 200 from 148. This Committee is to receive for its comment and advice, an industrial nurses' manual being compiled.

Respectfully submitted,
John R. Davis, MD, Chairman
Samuel N. Bacon, Jr., MD
Timothy D. Baker, MD
William F. Cox, III, MD
Walter E. Fleischer, MD
Herman J. Halperin, MD
Harry L. Knipp, MD
Donald J. Roop, MD
S. Jack Sugar, MD

POLICY AND PLANNING COMMITTEE

Mr. President and Members of the House of Delegates:

The Policy and Planning Committee has concerned itself with many topics having to do with the varied aspects of its province such as unity in the profession and the collection of biographic data on physician members of the Faculty.

One aspect of the Committee's interest was studied by the "Ad Hoc Committee to Consider Changes in the Medical Practice Act." This Committee was formed to strengthen and modernize the Medical Practice Act in general and to establish improved means by which the profession might be able to discipline its members for acts of unethical or unprofessional conduct. Its action along these lines was reported to the parent body, the Policy and Planning Committee.

The final draft of the changes in the Medical Practice Act was submitted to the Deans of the two medical schools, the Chief Medical Examiner, and the President of the Board of Medical Examiners for their perusal. The final draft is to be presented to the Council for approval, and will then go to the House of Delegates.

This Ad Hoc Committee, headed by John M. Dennis, MD, has proposed that a body other than the Board of Medical Examiners be established and charged with the responsibility for disciplining all physicians in the State, guilty of unethical or unprofessional conduct. This State body would consist of the following Medical and Chirurgical Faculty officers: the President, the President-elect, and the immediate Past President; the Dean of The Johns Hopkins University School of Medicine; the Dean of the University of Maryland School of Medicine; the Chief Medical Examiner of Maryland; and two practicing physicians appointed by the Governor from a list submitted by the Faculty.

The Policy and Planning Committee also heard from the Library Committee in connection with grants from the federal government for construction and expansion of services. It was moved that this library activity should be pursued and funds from any source (including government sources) should be considered so long as acceptance of such funds does not in anyway jeopardize our position or status.

Relative to the need of Maryland communities for additional physicians, it was resolved that this Committee should recommend to the Council that a committee be formed to visit the Deans of the medical schools to remind them that there is a continuing shortage of family physicians in Maryland and ask permission to address students of all classes to discuss with them the various aspects of family practice.

Respectfully submitted,
Eldridge H. Wolff, MD, Chairman
William A. Williams, MD, Vice-Chairman
J. Thompson B. Ambler, MD
A. N. Barr, MD
Leon W. Berube, MD
Joseph H. Caricofe, MD
Thomas V. Craig, MD
George E. Groleau, MD
Frederick J. Hatem, MD
William A. Holbrook, MD
Irvin G. Hoyt, MD
John C. Hyle, MD
Arthur T. Keefe, Jr., MD
Henry P. Laughlin, MD
Herbert H. Leighton, MD
William C. Morgan, MD
William H. Mosberg, Jr., MD
Earl R. Paul, MD
Harold B. Plummer, MD
Norman R. Sartorius, Jr., MD
Peter Stavrakis, MD
James B. Thomas, MD
Hugh W. Ward, MD
Arthur O. Wooddy, MD
J. Morris Reese, MD
Karl F. Mech, MD
Richard D. Bauer, MD
Russell S. Fisher, MD
J. Emmett Queen, MD
William A. Pillsbury, MD

AD HOC COMMITTEE TO CONSIDER CHANGES IN THE MEDICAL PRACTICE ACT: John M. Dennis, MD, Chairman, Lewis P. Gundry, MD, Karl F. Mech, MD, William A. Pillsbury, MD.

COMMITTEE ON POSTGRADUATE EDUCATION, PREVENTIVE MEDICINE, AND PUBLIC HEALTH

Mr. President and Members of the House of Delegates:

Although this large Committee has many Subcommittees, it is totally unlike the old woman in the shoe who had so many children she didn't know what to do. It is because of its multiple offspring that the parent body can obtain information on many problems, coordinate it, and pass on recommendations.

No action was taken by the Faculty Council on the Committee's recommendation that the Regional Medical Center (Heart, Stroke, and Cancer) program be approved. It was felt that there was no need for action on an already existing government program. The Council did, however, approve the recommendation that the Regional Medical Center be allowed to use the MEDIC network for an appropriate charge.

The *Subcommittee on Aging* recommended that endorsement be given to community sponsored nursing home facilities in all communities in Maryland where need is demonstrated for extended care facilities, nursing home care, and for custodial or domiciliary care. It was further moved that the Aging Subcommittee recommend that each local Commission on Aging stimulate activity in programming community sponsored nursing homes.

The *Subcommittee on Alcoholism* has been extremely active during the year, including discussions of conclusions reached by the Ad Hoc Committee on the Detoxification Center. A representative of the Alcoholism Subcommittee appeared in Annapolis during the current session of the Legislature in support of the budget for the Department of Mental Hygiene for funds to increase services for alcoholics. Several other bills were introduced in the State Legislature concerning alcoholism; one involved increasing the tax on beer to provide funds for alcoholic treatment facilities, and another to increase the tax on liquor for the same purpose.

Among the educational ventures engaged in by the Subcommittee was the distribution of some 77,000 pamphlets on the subject of alcoholism to the component societies for circulation to the high schools in their area. Prince George's County alone requested some 66,000 such pamphlets.

Other areas of discussion included the treatment of alcoholism in tuberculosis hospitals; in penal institutions; in industry; and transportation of the alcoholic to care facilities. A motion was sent to, and approved by, Council suggesting that staffs at the State Tuberculosis hospitals receive training in the treatment of the alcoholic/tubercular patient. No definitive actions were taken on the other items discussed.

The Subcommittee continued to encourage the allocation of beds in general hospitals for the treatment of alcoholics.

The *Subcommittee on Cancer* considered the establishment of a central cancer registry and good response was obtained to a canvass of the general hospitals in the State concerning such a registry. There are presently only a small number of hospitals with active cancer registries, but response to the canvass indicated that a majority of those in Maryland would be willing to cooperate. To be effective and accurate, such a registry would require a clerk for every 400 beds. Once the hospitals set up a registry, a carbon copy of the data collected could be sent to the central registry and coded for future use. While not of immediate value, its future value in observing trends in cancer could be most helpful.

The *Subcommittee on Child Welfare* has taken the lead in the campaign to designate May 21, 1967, as "End Measles Menace Sunday." This campaign is being sponsored by the Medical and Chirurgical Faculty, the State Health Department, local health departments, and the Maryland Jaycees. The Faculty allocated an amount of up to $15,000 from its Educational Fund for publicity purposes and will also underwrite other expenses. The condition for underwriting these expenses is that all components must use the vaccine provided by the Federal Government free for pre-school children and at a reduced cost for those of school age. A contribution of $1.00 for each immunization will be requested and will be used by the Faculty to defray the expenses, with any surplus to be kept in a special fund controlled by the Faculty and to be used for future immunization campaigns.

A booklet has been printed and distributed to the physicians of Maryland giving information on the child abuse law, which the Subcommittee was instrumental in formulating.

The *Subcommittee on Chronic Respiratory Diseases* has shown great interest in the subject of air pollution and has been vocal in support of the bill before the State Legislature to disband the present air pollution control council and replace it with an air quality control division of the State Health Department. It is particularly essential that a physician in the active practice of treating chest diseases be appointed to the State Board of Health and Mental Hygiene's Advisory Council since none has been represented there. There is such a physician now on the Baltimore City commission surveying means of air quality control.

Reports were submitted to this Subcommittee on such air pollution reduction agents as attachments in new automobiles to reduce the amount of sulphur dioxide expelled, and a new type of incinerator constructed to reduce the amount of fumes caused by burning of rubbish in Baltimore City.

The Subcommittee has attempted to locate funds from several sources for the establishment of a special facility at the Bolton Hill Nursing Home for the treatment of emphysema patients. This has not met with success. Contact will be made, however, to determine if facilities of the type necessary will be available at the new Good Samaritan Hospital being constructed.

The Subcommittee also discussed and approved the establishment of a clinic for ambulatory chronic respiratory disease patients to be operated by the Maryland General Hospital. This was endorsed by the Faculty Council.

The *Subcommittee on Continuing Medical Education,* which is charged with the operation of the MEDIC network, met as a whole twice during the past year. Three smaller groups were appointed to investigate separate areas of operation of the network. One will devise programs for the practicing physician; one will explore the possibility of broadening the programs to include presentations of particular interest to house staffs; and the third will investigate the potential uses of the network for the future.

For the coming year, programming will remain essentially the same, except that the Friday noon programs will all be produced from one of the community hospitals other than The Johns Hopkins or University Hospitals. However, the faculties of the latter two have expressed willingness to participate by giving lectures from the community hospitals. It is hoped that by this means the participation by each hospital in the network will be expanded. The Grand Rounds presentations will continue and additional programs will be added as plans are completed.

Other than scientific programs, the MEDIC network has been used by physicians for contacting the Faculty office to discuss matters with the accounting department, the administrative staff, and to borrow books from the library. Meetings have been held via the network by several medical and paramedical groups. As the availability of this type communication becomes more widely known, it is anticipated that many more physicians in the counties of Maryland will avail themselves of this fast and inexpensive means of contacting the Faculty offices in Baltimore.

Future plans for the network also include "spot announcements" to be broadcast prior to regularly scheduled programs to keep the physicians of the State informed of Faculty activities. In this way, information can be transmitted throughout the State simultaneously and without the delay and expense of mailings.

At this time the outlook is pessimistic for the possibility of using the Maryland Educational-Cultural Television network because of the lack of "prime-time" available for the relatively small physician audience.

While the Subcommittee realizes that MEDIC may not be the very best solution to the problem of making postgraduate programs available to all physicians in Maryland, it does eliminate the two hurdles of time and distance. Much discussion has been held as to the best time for program presentations, but as there is no optimum time at which all physicians could attend presentations, it was agreed that the Friday noon conferences will be continued. Tapes of all programs are made, however, and are available, with slides and printed material, for the use of any physician or group of physicians. These may be borrowed by contacting the Faculty office.

Although the MEDIC network has increased in usefulness to the physicians in Maryland, there still remains much that can be done. The Subcommittee was in agreement that the adaptability of the network is only now being explored and that its fullest potential may not be realized for several years.

The network now includes 30 hospital locations, a growth of 18 new hospitals from the beginning of the network in October 1965 when it included only 12 hospitals.

The Committee on Postgraduate Education, Preventive Medicine, and Public Health, therefore, recommends that the House of Delegates allocate from the Faculty's Educational Fund an amount of up to $15,600 for the continuation of the MEDIC network for the period from July 1967 to July 1968. These funds to be used for the actual transmission cost incurred by the network and the rental of the equipment at the Medical and Chirurgical Faculty office. This figure is based on the present monthly cost projected for a twelve month period.

The funds previously allotted ($25,000), have supported the operation of the network since its inception in October 1965 with enough remaining to continue operation through June 1967, a period of 21 months.

Appreciation is expressed to the administrators of each of the participating hospitals for their cooperation, and to the MEDIC representative at each hospital on whom falls the burden of detail work involved in presenting and evaluating the programs. Without the dedicated efforts of all of these persons, MEDIC could not operate successfully.

The *Maternal Welfare Subcommittee* has enlarged its membership and scope of activities during the past year. Among the decisions made was that if the Subcommittee were invited, the meetings would be held in conjunction with component society meetings throughout the State. This would involve either case presentations or presentations of other educational material. At present two such invitations have been received. In order to ob-

tain more detailed information concerning the maternal deaths occurring throughout the State, it is hoped that one person in each area can be designated to obtain from the physician in charge of the case, the authority to study the case and report to the Subcommittee.

All maternal deaths occurring in the State are reviewed by the Subcommittee. A report of the number of deaths and other pertinent material is shown in Tables I and II.

Future activities of the Subcommittee will include meetings with representatives of the Police Abortion Squad and the study of perinatal deaths in Maryland.

It was also resolved by the Subcommittee that whenever the entire Subcommittee studies a specific case, the physician involved will be invited to attend the meeting.

The Faculty Council, at the request of the Subcommittee approved a statement "That the Medical and Chirurgical Faculty go on record as recognizing the provision of family planning advice serves as an integral part of the practice of medicine, and that it urges the physicians of Maryland to provide such advice and services as are consistent with their own personal and moral convictions and those of their patients."

TABLE I

PROVISIONAL MATERNAL MORTALITY RATES*

	1966 No.	1965	1966 Rate	1965
Baltimore City	11	14	5.7	7.0
Total Counties	9	19	1.7	3.4
Total State of Maryland	20	33	2.8	4.3

*Per 10,000 live births.

The causes of death, by diagnosis, in these obstetric patients are shown in the following table.

TABLE II

CAUSES OF MATERNAL MORTALITY

	White	Non-White	Total
Hemorrhage			
Ruptured Ectopic	1	0	
Post Partum	1	0	
Ruptured Uterus	1	1	
Abortal	0	2	6
Infection			
Post Abortal	0	3	
Puerperal	1	1	5
Toxemia			
Eclampsia	2	1	
Unclassified	0	0	3
Embolism			
Pulmonary	1	2	
Amniotic Fluid	0	0	3
Other			
Anesthesia Accident	1	0	
Cardiac Arrest	1	0	
Sickle Cell Anemia	0	1	3
GRAND TOTAL	9	11	20

The *Subcommittee on the Medical Aspects of Sports*, a new group, charged with concern for all types of sports activities including professional, collegiate, primary and secondary schools, as well as individual participation, had an interesting first year. For 1966-67, it was agreed that the most urgent need for attention was in the area of secondary school sports in Maryland, and consequently extensive investigation of such athletic programs was undertaken.

It is planned that guidelines for physical examinations for prospective athletes be formulated and distributed to the physicians in Maryland.

A meeting at the Round Table Luncheon during the Faculty Annual Meeting was arranged by this Subcommittee and will be open to all physicians who wish to participate.

The Subcommittee on the Medical Aspects of Sports agreed that, if at all possible, a physician be in attendance at all high school football games played in the State and available by phone for all other contact sports contests.

The *Speakers' Bureau Subcommittee* has not yet been organized, but is charged with compiling a list of speakers and topics of interest to the medical profession and making programs available to the component societies upon request.

The *Traffic Safety Subcommittee* has had an active and stimulating year. A widely attended Traffic Safety Seminar was planned by an Ad Hoc Committee. As a result of this Seminar, held on October 12, 1966, legislation involving visual acuity for drivers, and a reportable disease law was introduced in the 1967 State Legislature. The proceedings from this Seminar were published in the *Maryland State Medical Journal* with reprints available to interested groups.

In trying to coordinate the recommendations as to standards for physical examinations for licensed drivers, considerable study went into the visual acuity requirements. The final recommendation sets forth a minimum corrected visual acuity of 20/40 in one eye. The present standard in Maryland of 20/70 is one of the lowest in the country. It was agreed to accept the recommendation in this respect made by the Maryland Ophthalmological Society.

The Reportable Disease law stirred considerable controversy both within the medical profession and among legislators. Some eleven physical and mental conditions were finally included in the proposed law as reportable to the Medical Advisory Board of the Department of Motor Vehicles. None of these would automatically bring a loss of license, but would mean that records would be reviewed and if there were a question of an individual's ability to drive safely, he would be asked to appear before the Board with consequent recommendations as indicated.

The final disposition of these two bills will be reported in the report of the Legislative Committee to the House of Delegates.

Respectfully submitted,
John H. Hirschfeld, MD, Chairman
Ruth Workman Baldwin, MD
Robert G. Chambers, MD
H. Garland Chissell, Jr., MD

JOHN B. DE HOFF, MD
ROBERT E. FARBER, MD
MARION FRIEDMAN, MD
KARL M. GREEN, MD
LEWIS P. GUNDRY, MD
FREDERICK J. HELDRICH, JR., MD
MILTON B. KRESS, MD
C. RODNEY LAYTON, MD
WILLIAM J. PEEPLES, MD
J. EMMETT QUEEN, MD
EMERSON C. WALDEN, MD
JOHN WHITRIDGE, JR., MD
JOSEPH B. WORKMAN, MD

SUBCOMMITTEE ON AGING: C. Rodney Layton, MD, Chairman, Archie R. Cohen, MD, W. Grafton Hersperger, MD, Page C. Jett, MD, Louis Krause, MD, Herman Seidel, MD, Hugh W. Ward, MD.

SUBCOMMITTEE ON ALCOHOLISM: Lewis P. Gundry, MD, Chairman, Abraham M. Schneidmuhl, MD, Vice-Chairman, Conrad Acton, MD, Edmund G. Beacham, MD, John R. Davis, MD, Irene L. Hitchman, MD, Frank L. Iber, MD, Isadore Kaplan, MD, Harry F. Klinefelter, MD, Kenneth Krulevitz, MD, Maxwell N. Weisman, MD, R. Lane Wroth, MD.

SUBCOMMITTEE ON CANCER: Robert C. Chambers, MD, Chairman, Cyrus L. Blanchard, MD, Fernando G. Bloedorn, MD, Elizabeth G. Brings, MD, Earl C. Clay, Jr., MD, John B. De Hoff, MD, Louis E. Goodman, MD, Howard W. Jones, Jr., MD, Conrad G. Julian, MD, George A. Maxwell, MD, Alan C. Woods, Jr., MD.

SUBCOMMITTEE ON CHRONIC RESPIRATORY DISEASES: Milton B. Kress, MD, Chairman, Warde B. Allan, MD, Edmund G. Beacham, MD, Otto C. Brantigan, MD, Robert E. Farber, MD, A. Murray Fisher, MD, Meyer W. Jacobson, MD, Elliott Michelson, MD, John E. Miller, MD, William K. C. Morgan, MD, William J. Peeples, MD.

SUBCOMMITTEE ON CHILD WELFARE: Karl M. Green, MD, Chairman, Raymond L. Clemmens, MD, Murray M. Kappelman, MD, Lawrence C. Pakula, MD, Benjamin D. White, MD, Robert E. Yim, MD.

SUBCOMMITTEE ON CONTINUING MEDICAL EDUCATION PROGRAMS (MEDIC): Frederick J. Heldrich, Jr., MD, Chairman, Samuel P. Asper, MD, Edmund G. Beacham, MD, Raymond F. Caplan, MD, Julius Chepko, MD, Edward F. Cotter, MD, Irving Freeman, MD, Samuel Gaby, MD, David J. Gilmore, MD, H. Logan Holtgrewe, MD, Carl J. Houmann, MD, Arthur T. Keefe, MD, Alfred R. Lapin, MD, Thomas K. Mahan, MD, Albert P. Marsh, MD, J. G. Barry Mason, MD, Robert E. May, MD, William C. Mulford, MD, Thaddeus E. Prout, MD, Aubrey D. Richardson, MD, I. Randall Ross, MD, William Schuman, MD, George M. Simons, MD, John C. Stauffer, MD, Gerald Wagger, MD, George J. Weems, MD, Walter Welzant, MD, R. Lane Wroth, MD, Richard A. Yates, MD, John D. Yun, MD.

SUBCOMMITTEE ON DIABETES: J. Emmett Queen, MD, Chairman.

SUBCOMMITTEE ON MATERNAL WELFARE: John Whitridge, Jr., MD, Chairman, J. Tyler Baker, MD, George H. Davis, MD, Rafael Garcia-Bunuel, MD, Gerald B. Holzman, MD, D. Frank Kaltreider, MD, Hugh B. McNally, MD, Edwin R. Ruzicka, MD, J. King B. E. Seegar, MD, Joseph N. Seitchik, MD.

SUBCOMMITTEE ON THE MEDICAL ASPECTS OF SPORTS: John B. De Hoff, MD, Chairman, James W. Banks, MD, William C. Duffy, MD, Robert G. Brewer, MD, George O. Himmelwright, MD, J. Parran Jarboe, MD, John M. Krager, MD, Edmond J. McDonnell, MD, Ross Z. Pierpont, MD, Leonard Wallenstein, MD, Marcus Stephanides, MD.

SUBCOMMITTEE ON TRAFFIC SAFETY: Ruth Workman Baldwin, MD, Chairman, Timothy D. Baker, MD, Solomon E. Barr, MD, Rudiger Breitenecker, MD, William H. M. Finney, MD, Irene L. Hitchman, MD, William P. Horton, MD, Howard F. Kinnamon, MD, Paul H. Royse, MD, Robert J. Wilder, MD.

AD HOC COMMITTEE ON TRAFFIC SAFETY SEMINAR: Rudiger Breitenecker, MD, Chairman, Timothy D. Baker, MD, Kay K. Edwards, MD, Harold P. Biehl, MD, Abraham J. Mirkin, MD.

COMMITTEE ON PROGRAM AND ARRANGEMENTS

Mr. President and Members of the House of Delegates:

Arrangements have been completed for the 169th Annual Meeting of the Medical and Chirurgical Faculty to be held at the Alcazar, April 19, 20, 21, 1967. All prominent out-of-State speakers have been obtained for the scientific sessions. As in previous years, there will be the annual Round Table Luncheon, Presidential Dinner, technical and scientific exhibits, and Health Evaluation Tests.

The 168th Annual Meeting in 1966 was most successful with a registration of approximately 1,200, of which 850 were physicians. All technical exhibit space was sold and a favorable rating was received from the Medical Exhibitors Association. An award was given by a pharmaceutical company for the outstanding scientific exhibit. The Committee on Program and Arrangements judged the exhibits, and a member of the Faculty was the co-author of the award winning exhibit. The Health Evaluation Tests were again taken by over 200 physicians, and many previously unknown abnormalities revealed.

The meeting was continued from April 29 to May 4, 1966 aboard ship to and from Bermuda. There were scientific sessions held and medical films shown each day, and these were extremely well attended, with a registration of 650 taken for attendance at the sessions. Because of the complete success of this cruise convention, Council approval has been received for a Caribbean Cruise Convention as part of the 1968 Annual Meeting.

The headquarters hotel for the 1966 Semiannual Meeting was the Diplomat Motor Hotel in Ocean City, Maryland. Facilities proved adequate and accommodations in general were most attractive and comfortable. All reservations were sold for the crab feast and dinner dance, which were held respectively at Phillips Crab House and The Diplomat. The day following the meeting of the Faculty, there were scientific sessions at the Diplomat by the Maryland Chapter of the College of Surgeons, the Maryland Psychiatric Society, and the Maryland Diabetes Association.

Our Committee expresses its appreciation to the Faculty members who have so willingly and ably assisted in making these meetings successful, and to the Faculty staff for its cooperation and untiring efforts in carrying out the many details in connection with the meetings.

Respectfully submitted,
JAMES B. BROOKS, MD, Chairman
THADDEUS E. PROUT, MD
JOSEPH D. B. KING, MD
DEWITT E. DELAWTER, MD
JOSEPH H. SEIPP, JR., DDS

SUBCOMMITTEE ON EXHIBITS: Thaddeus E. Prout, MD, Chairman; Joseph D. B. King, MD, Sheldon Friedman, Richard R. Crane.

PUBLIC RELATIONS COMMITTEE

Mr. President and Members of the House of Delegates:

A wide area of discussion covering many facets of public relations occupied the Public Relations Committee during the past year.

One of the main new fields of interest was career recruitment with the naming of a consultant to the Committee to serve as liaison between the Faculty and medical schools in health careers. His specific assignments were to make the schools aware that career material is available and to find responsible persons in the medical schools to help.

A Speech Training Seminar conducted by Smith Kline and French in October attracted some 50 participants and was judged an excellent seminar. Also successful was the Office Assistants Seminar held in the spring with consideration given to making such regional in nature.

Responsibility by this Committee for MEDIC was dropped, but it was suggested to the Continuing Medical Education Subcommittee, now responsible, that current news notes and tips to doctors might be used over the network as "spot" announcements.

The possibility of establishing a Boy Scout Explorer Medical Post is being explored, and lengthy consideration has been devoted to the possibility of docking the Shipe HOPE in Baltimore some time in the future.

Because of intense interest in the quarterly meetings of executive secretaries of component societies held on a year's trial basis, it was recommended that these be continued on a permanent basis. A similar type of meeting for presidents and secretaries of component societies was also proposed for discussion.

Representatives of the SAMA chapter at the University of Maryland reported on the growing interest in the annual Career Day held at the University of Maryland School of Medicine. Invitations this year went beyond the high school students previously invited and included private school students, as well as college students. It was also reported that an attempt was being made to establish a chapter of SAMA at The Johns Hopkins University School of Medicine. They now have members-at-large in the University of Maryland chapter.

Interest was expressed by the Public Relations Committee in the Health Fair sponsored by CICHA during Community Health Week, in 1967, which has been given Faculty Council endorsement.

The Committee also concerned itself at its meetings with news stories, books, etc. which engender controversy involving the medical profession. Good rapport with the news media was endorsed as the best means of countering a bad image of medicine.

Respectfully submitted,
MANNING W. ALDEN, MD, Chairman
DAVID S. CLAYMAN, MD
ROBERT B. GOLDSTEIN MD
CALVIN Y. HADIDIAN, MD
E. RODERICK SHIPLEY, MD
Advisory members:
H. BERTON MCCAULEY, DDS
JOSEPH SEIPP, DDS
MRS. H. LEONARD WARRES
WILLIAM B. WEGLECKI, MD

REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

Your Reference Committee met on Wednesday, March 29, 1967, to consider the five resolutions introduced by four individual members as well as by one component medical society. An unusually large number of persons was in attendance at our meeting and full discussion was entered into by all. As usual, the motions made will be on the resolution itself.

RESOLUTION 1A/67

Submitted on: June 28, 1966

Introduced by: Prince George's County Medical Society

Subject: Condemning Attempts by Insurance Carriers to Determine Qualifications of Physicians; and Requesting That Such Carriers Amend Their Regulations to Prevent This.

Whereas, Maryland Medical Service, Incorporated, indicates in its *Participating Physicians Manual*, at page 26 (Rev. 2-66) that benefits will be available to its subscribers for diagnostic x-ray services only when such services are performed by physicians conforming to certain criteria established by Maryland Medical Service, Incorporated; and

Whereas, The proper practice of medicine requires the exercise of all of a physician's skills and qualifications; and

Whereas, The condoning of such regulation of medical practice by economic means may lead to further propagation of such restrictions, which are contrary to the best interests of the patient; and

Whereas, Such restrictions are not imposed upon Maryland physicians by licensure; now, therefore, be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland condemns any attempt by any insurance company to determine for its subscribers which duly licensed physician is qualified to perform what medical procedure and requests that all insurance carriers doing business in this State amend their regulations accordingly.

On April 28, 1959, the Council of the Faculty, in consultation with Maryland Medical Service, Inc., (Blue Shield) and the Maryland Radiology Society, took the following action:

1. *Specific Specialty:* The doctor confining his practice to a specific specialty (excluding general surgery, internal medicine and general practice) will be paid for diagnostic X-rays within the confines of such a specialty (example—orthopedics).
2. *General Surgery:* The doctor confining his practice to general surgery will be paid for diagnostic X-rays necessary in emergency traumatic cases.
3. *Internal Medicine:* (a) the doctor confining his practice to general internal medicine will be paid for diagnostic X-rays of the chest; (b) the doctor confining his practice to a *subspecialty of internal medicine*, such as thoracic diseases, joint diseases, or gastroenterological disease, will be paid for diagnostic X-rays within the confines of such a subspecialty.
4. *General Practice:* The doctor in general practice will be paid for diagnostic X-rays necessary in emergency traumatic cases and chest.
5. In rural areas and small communities where a radiologist is not available within approximately ten miles, consideration of payment for diagnostic X-rays will be given on an individual doctor basis. In most instances, this would be only for the diagnostic X-rays necessary in emergency traumatic cases.

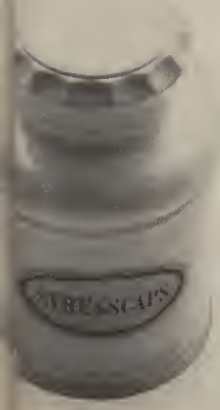
ACTION: On motion duly made, seconded and carried, it was voted to approve the provision of Diagnostic X-ray coverage as suggested by the Maryland Medical Service, Inc., as amended by the above policy modifications, under Blue Shield policies only.

On November 18, 1965, the Council reaffirmed that this policy remain in effect. From this background informa-



in chronic illness

B and C vitamins are part of therapy: An imbalance of water-soluble vitamins and chronic illness often go hand in hand. STRESSCAPS capsules, containing therapeutic quantities of vitamins B and C, are formulated to meet the increased metabolic demands of patients with physiologic stress. In chronic illness, as with many stress conditions, STRESSCAPS vitamins are therapy.



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FOR PROFESSIONAL
RECOMMENDATION ONLY

Each capsule contains:

Vitamin B_1 (as Thiamine Mononitrate)	10 mg
Vitamin B_2 (Riboflavin)	10 mg
Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Vitamin C (Ascorbic Acid)	300 mg
Niacinamide	100 mg
Calcium Pantothenate	20 mg

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

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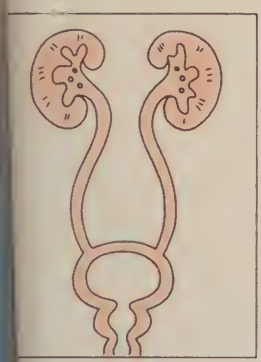
628-6—3614

When the battle with bacteria is in the G. U. tract

Artist's conception of acute infection
showing G.U. pathogens with predominance of *E. coli*.



consider Gantanol (sulfamethoxazole)



For vigorous treatment of G.U. infections before the invaders become entrenched... Gantanol (sulfamethoxazole) offers a comprehensive spectrum of antibacterial effectiveness against most common gram-negative as well as gram-positive invaders. In addition, it provides satisfactory concentrations in the blood and urine with ready diffusion to interstitial fluids for antibacterial activity at foci bacterial invasion.

gh antibacterial activity against *E. coli* and other mmon urinary pathogens... A review of 153 cases of ute G.U. infections reported in the literature shows that 90% responded to Gantanol (sulfamethoxazole), with over one-half of these patients showing excellent relief of symptoms.[1,2] Even in stubborn chronic G.U. infections, almost 60% of 450 patients improved on Gantanol (sulfamethoxazole), including many who had not responded to other antibacterials.[1-6]

Generally uncomplicated therapy enhances the favorable clinical results... Of the total 686 patients from the studies cited,[1-6] only three discontinued therapy because of side effects. Most of the side effects reported (approximately 3%) were mild and included nausea and/or vomiting, skin rash, dizziness, headache, gastritis, generalized uneasiness and itching.[1-6]

1. Peters, J. H.: *J. Urol.*, 87:747, 1962. 2. Draper, J. W., *et al.*: *South. M. J.*, 57:920, 1964. 3. Stewart, B. L.: *J. Urol.*, 87:491, 1962. 4. Hagstrom, R. S.: *Rocky Mountain M. J.*, 59:(2), 37, 1962. 5. Arnold, J. H.: *Clin. Med.*, 71:552, 1964. 6. Nelson, C. G.: *Colorado GP*, 3:(3), 2, 1961.

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fore prescribing, please consult complete product ormation, a summary of which follows:

ntraindicated in sulfonamide-sensitive patients, gnant females at term, premature infants, or newn infants during first three months of life.

rnings: Use only after critical appraisal in patients n liver damage, renal damage, urinary obstruction lood dyscrasias. If toxic or hypersensitivity reacs or blood dyscrasias occur, discontinue therapy. In rmittent or prolonged therapy, blood counts and and kidney function tests should be performed.

autions: Observe usual sulfonamide therapy preions, including maintenance of an adequate fluid ke. Use with caution in patients with histories of gies and/or asthma. Patients with impaired renal tion should be followed closely since renal impairt may cause excessive drug accumulation. Occaal failures may occur due to resistant microorgan. Not effective in virus or rickettsial infections.

erse Reactions: Headache, nausea, vomiting, urtia, diarrhea, hepatitis, pancreatitis, blood dyscrason syndrome, injection of the conjunctiva and sclera, petechiae, purpura, hematuria or crystalluria may occur, in which case the dosage should be decreased or the drug withdrawn.

Dosage: Adults—4 tablets initially, then 2 tablets b.i.d. or t.i.d. depending upon severity of infection. Children —1 tablet/20 lbs initially, followed by ½ tablet/20 lbs b.i.d.

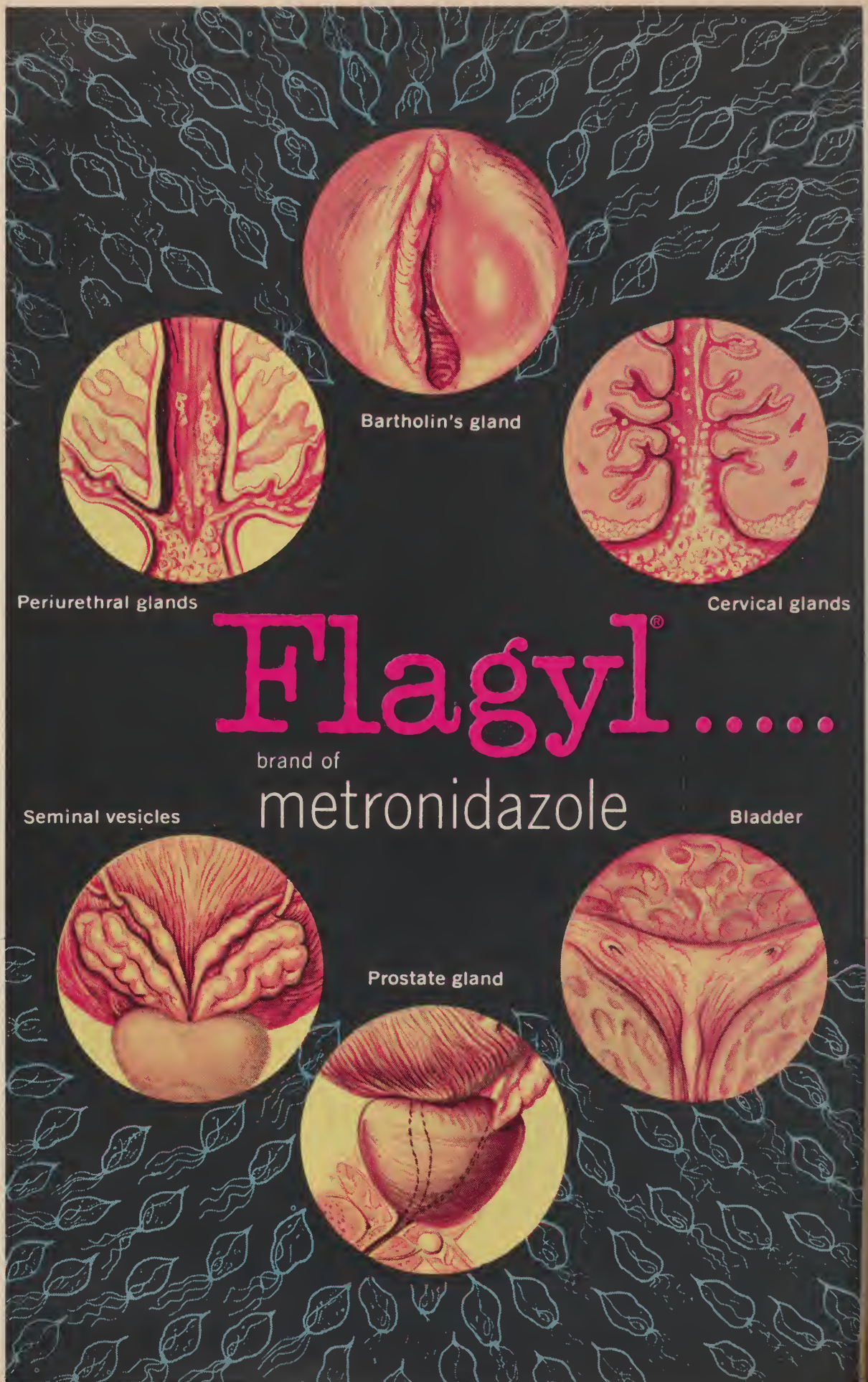
How Supplied: Tablets, 0.5 Gm, bottles of 50.

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Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

when there are bacterial invaders in the bladder, prostate or kidneys

Gantanol®
(sulfamethoxazole)


Bartholin's gland
Periurethral glands
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brand of
metronidazole
Seminal vesicles
Bladder
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Destroys Trichomonads Wherever They Are

Flagyl seeks out the sites where trichomonads hide. Only a systemic agent can. Flagyl does, selectively and effectively.

Flagyl destroys trichomonads in the inner crypts, glands and cavities of the genitourinary tract in both women and men. Consequently, Flagyl is capable not only of curing trichomoniasis in women but also of preventing reinfection.

Correctly used, with due attention to repeat courses of treatment for resistant, deep-seated invasion and to the presumption of reinfection from male consorts, Flagyl has repeatedly produced up to 100 per cent cure in large series of patients.

When the diagnosis of trichomoniasis is positive, Flagyl is positive.

Dosage and Administration — In *women:* one 250-mg. oral tablet three times daily for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.

In *men* in whom trichomonads have been demonstrated: one 250-mg. oral tablet twice daily for ten days.

Contraindications — Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precaution—Complete blood cell counts should be made before, during and after therapy, especially if a second course is necessary.

Side Effects—Infrequent and minor side effects include nausea, metallic taste, furry tongue and headache. Other effects, all reported in an incidence of less than 1 per cent, are diarrhea, dizziness, vaginal dryness and burning, dry mouth, rash, urticaria, gastritis, drowsiness, insomnia, pruritus, sore tongue, darkened urine, anorexia, vomiting, epigastric distress, dysuria, depression, vertigo, incoordination, ataxia, abdominal cramping, constipation, stomatitis, numbness of an extremity, joint pains, confusion, irritability, weakness, flushing, cystitis, pelvic pressure, dyspareunia, fever, polyuria, incontinence, decreased libido, nasal congestion, proctitis and pyuria. Elimination of trichomonads may aggravate candidiasis.

SEARLE *Research in the Service of Medicine*

Did Dorothy Larson show you her ankles in private? Now she shows them in public.

Your office examination would have confirmed that Mrs. Larson was up to her knees in edema. Her heart was beginning to fail. And her ankles had disappeared under an inch of salty water.

Along with digitalis, you might have prescribed Hygroton. To get rid of the edema. And to keep it from coming back. And you prescribe Hygroton the same way you usually prescribe digitalis: just once a day.

Tablet for tablet, Hygroton is just about the most effective diuretic going. And it costs a fraction of what Mrs. Larson would have to spend for equivalent therapy with short-acting diuretics.

In fact, Hygroton is an awfully nice way to treat the Mrs. Larsons in your practice. Just tell them you can get their ankles back at half price.



Indications: Hypertension and many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.

Warning: With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.
Precautions: Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if BUN rises or liver dysfunction is aggravated. Electr imbalance and potassium depletion may occur; ta special care in cirrhosis or severe ischemic heart d



patients receiving corticosteroids, ACTH, or digi-
alt restriction is not recommended.
fects: Dizziness, weakness, nausea, vomiting,
ycemia, hyperuricemia, headache, muscle cramps,
postural hypotension, constipation, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin reactions, including urticaria and purpura, epigastric pain, or G.I. symptoms after

Average Dosage: One tablet (100 mg.) with breakfast daily or every other day.
Availability: Tablets of 100 mg. 6524-V(B)
For full details, see prescribing information.

...so you might say Hygroton is good public relations for Mrs. Larson

Because it gets her *out* in public in the first place. At 43, Mrs. Larson worries about appearances and swollen ankles don't help.

But Hygroton's cosmetic effect is only half the story. Hygroton and digitalis therapy helps her get back in the swing of things. Gives her a second wind. Gets rid of the extra pillow she needed for a good night's sleep. Now she even likes to take walks. Just for the fun of it!

When her troubles began, Mrs. Larson thought they were the signs of the change of life. It's a change all right, but one you can treat. And you can count on Hygroton to help keep her in public instead of in the hospital.

See preceding pages for brief summary of prescribing information.



Geigy

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

tion, it can be seen that little, if any, hardship is being developed by this policy determination.

In testimony heard before the Committee, it was ascertained that Blue Shield would find it extremely difficult to properly police the indiscriminate taking of X-rays.

We are in general agreement that third party carriers should not, on their own, establish criteria for payments of physicians under regulations issued by them. The criteria involved and mentioned in this resolution was developed in cooperation with the Faculty, representing the medical profession. It is not known of any other instance where Insurance Companies have developed such restrictions on their own. If any difficulties arise in this connection, they should be channeled through the Faculty's Mediation Committee.

We see no reason, therefore, to change the established policy in this regard.

Your Reference Committee recommends that this resolution *NOT* be adopted.

RESOLUTION 2A/67

Submitted on: January 9, 1967

Introduced by: M. B. Levin, MD

Subject: Authorizing the State Board of Medical Examiners, in Concert With Specialists, to Determine the Qualifications of Such Specialists; Providing for Election of the Board of Medical Examiners by Mail Ballot; Broadening the Powers of the Board of Medical Examiners to "Control and Regulate the Entire Practice of Medicine . . . in the State of Maryland"; and Making Other Recommendations Relating to Its Operation, Status and Composition; and Providing Certain Things That Are Now Governed By State Law or Regulation.

Whereas, The goal of the medical profession, ie, to obtain the highest possible standard of health and the greatest improvement of medical practice for the public's benefit, may finally be won through enabling the patient to have his own chosen doctor treat him at any institution he chooses (including hospitals), within the State limits; and

Whereas, This type of private practice of medicine is the objective of our Medical and Chirurgical Faculty; and

Whereas, Corporate Private practice of medicine is not permitted in Maryland; and

Whreas, Corporate control, intervention or denial in the private practice of medicine is not in the best interest of or for the benefit of the public's health and welfare; and

Whereas, Our laws regarding the public's health and welfare should be more definitive in this regard; and

Whereas, The medical profession being the only one having intimate and detailed knowledge of the requirements, standards and qualifications of the profession to practice medicine for the public's health and welfare; and

Whereas, The State authorizes only its State Board of Medical Examiners in cooperation with the Medical and Chirurgical Faculty and the profession, to qualify, license, regulate and control the practice of medicine throughout Maryland; now, therefore, be it

Resolved, That the Legislature authorize only the State Board of Medical Examiners to be so constituted as to enable it to thoroughly accomplish its purpose and fully assume its sole activity and responsibility, and thereto enact the following:

There shall be a Maryland State Board of Medical Examiners composed of at least eight (8) active members and it shall have such powers, duties, officers and meetings as are provided from time to time by law. This Board shall be so constituted as to qualify and license not only new members of the profession, but also be assisted in determining the qualifications of members in the Specialties by corresponding Specialists in their respective fields, with the advice and approval of the entire profession in the State.

The Maryland State Board of Medical Examiners shall be elected by a majority vote of the general voting membership of the Medical and Chirurgical Faculty of Maryland and other eligible doctors in good standing in the State, voting by secret ballot through the mail.

One-fourth of the members of the Board of Medical Examiners shall be nominated one month before the annual election of officers and delegates by the nominating committee of the House of Delegates; and, additional nominations may be made at a corresponding time by physicians in good standing at component society meetings, from the floor. These nominations shall be circulated to the entire general voting membership of the Medical and Chirurgical Faculty and be available to all physicians in good standing in the State; and, election of the members of the Board of Medical Examiners (as well as delegates and other officers) shall be by secret ballot through the mail. The elected Board members shall serve for a term of four years, or until their successors are elected and qualified, beginning on the first day of June following their election, or as provided by law.

The State Board of Medical Examiners and its Qualifying and Disqualifying Boards shall be so constituted and after due process of consultation, with the advice and assistance of the Medical and Chirurgical Faculty; and, in compliance with parliamentary procedure and statutory laws and medical ethics, shall have the sole and complete authority and responsibility to qualify, disqualify, license, control and regulate the entire Practice of Medicine, Surgery and the Specialties, everywhere and anywhere in the State of Maryland; and, no other bodies, including individuals, hospitals or other corporations, groups, or branches of Government, shall have authority and responsibility to qualify, disqualify, license, control, regulate, deny, interfere with or intervene in the above, directly or indirectly, without specific definitive legislation to that effect, as noted at present relative to the Health Commissioners.

The State and its components shall not be contractual parties with or give tax suppored financial or subsidized aid in any form to any hospital, institution or other corporation, or group participating in medical practice which denies the State Board of Examiners' properly qualified and licensed doctors in good standing, the use of their beds and facilities for their private practice of medicine.

If financial support or subsidy, including a tax-free status, is granted to such a body; and, it in turn in its contracts with hospitals or other institutions, bodies or groups, permits discrimination against doctors in good standing and refuses them the right to practice on their private patients by denying them access to the beds and facilities; or, requires of the doctors signed applications to abide by the hospital or corporate bylaws and control of the practice of medicine; state contracts, financial support, subsidy or tax-free status shall be cancelled.

Your Reference Committee heard comments from the Board of Medical Examiners as well as Dr. Levin and others.

It was of the opinion that this resolution involves too many suggestions and proposals involving policy matters both of the Board of Medical Examiners and the medical profession itself. In addition, it would require substantial changes in the laws of the State of Maryland.

It is, therefore, recommended that this resolution *NOT* be adopted.

RESOLUTION 3A/67

Submitted on: February 2, 1967

Introduced by: George Vash, MD

Subject: Closing of All Well-Baby Clinics and Transfer of Patients to Private Physicians

Whereas, Medicaid extends full benefits to our indigent people in Maryland; and

Whereas, The best care of the growing infant and child can be given by the family physician or pediatrician, who can watch the child in its good and bad days, and develop a personal relationship with the child and the family which will enable him to treat the child better if sickness develops; and

Whereas, It seems that the so-called well baby clinics, which specialize in administering immunizations and observing growth of the normal child, have no more justification and no further part to play although the contributions of these clinics in the past, when indigent mothers had difficulty obtaining services of private physicians, were outstanding; now, therefore, be it

Resolved, That the Medical and Chirurgical Faculty go on record favoring closure of all well baby clinics and transfer of their patients to private physicians.

Unfortunately, Dr. Vash was unable to attend the Reference Committee hearing. It was also learned that there is a continuing shortage of both Pediatricians and General Practitioners available to take care of children, particularly in the areas where such Well-Baby clinics are operated. If the Well-Baby clinics were closed, existing clinical facilities to which these patients could turn would be overtaxed. Efforts are being made to increase such services through community programs and this resolution was thought to be premature in its concept of a "personal relationship."

It is recommended, therefore, that Resolution 3A/67 *NOT* be adopted.

RESOLUTION 4A/67

Submitted on: February 22, 1967

Introduced by: Robert L. Cavenaugh, MD

Subject: Urging Faculty Members to Use the Democratic Processes for Correction of Impropriety in any Laws, Rules or Regulations; and Obey Any Such Laws Until They are Properly Changed

Whereas, The progressive development of individua's and communities requires freedom from infringements against life, liberty and pursuit of happiness; and

Whereas, To assure freedom from such infringements, Governments and Governing bodies, with the consent of the governed, properly enact laws, rules and regulations; and

Whereas, Disrespect to law and order, and disobedience of properly enacted laws, rules and regulations leads to demoralization of individuals and deterioration of civilized communities; now; therefore, be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland hereby reaffirms its wholehearted support of all properly enacted laws, rules and regulations, and encourages its members to respect and obey them, demonstrating to their fellow-citizens, particularly the youthful, an example of obedience to the letter and spirit of the laws of the land; and be it further

Resolved, That the members of the Medical and Chirurgical Faculty of the State of Maryland, individually and collectively, hereby state, that whenever any law, rule or regulation comes to their attention as being probably improper or probably not conducive to the progressive development of citizens or communities, it is their intent to bring about correction of such impropriety through the democratic processes which represent the proud heritage of American citizens, but to obey such directives until they are properly changed.

The medical profession has consistently used the existing democratic processes for the purpose of modifying or changing any laws, rules or regulations, when it considers them not in the best interests of the health of the people of Maryland. At times, such regulations or laws are promulgated despite the profession's concern over the effect they might have. Nonetheless, they become the law of the State or the Country and as such should be properly obeyed.

In these days of world-wide turmoil we believe it is well to reiterate this policy. **Your reference Committee, therefore, recommends that Resolution 4A/67 be adopted.**

RESOLUTION 5A/67

Submitted on: February 22, 1967

Introduced by: Timothy D. Baker, MD, Baltimore City

Subject: Reiteration of the Faculty's Policy to Assist the State Health Department in Maintenance of High [Ethical] Standards in Maryland's Title 19 Medical Care Program

Whereas, The Medical and Chirurgical Faculty of the State of Maryland has shown, [through its Mediation Committee and its Health Insurance Review Subcommittee,] its deep continuing concern with the maintenance of high [ethical] standards of medical practice, thus ensuring public confidence in the medical profession; and

Whereas, Some State Title 19 medical care programs have reported questionable practices that might diminish public confidence in the medical profession; now, therefore, be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland take the initiative and reiterate again the Faculty's offer of assistance to the State Health Department in the maintenance of high [ethical] standards of medical practice in the provision of medical services through Maryland's Title 19 program of medical assistance.

This resolution is self-explanatory. There presently exist mechanisms for the proper adjudication of difficulties that might arise with physicians in the operation of the Title 19 program (Medicaid). The Society reemphasizes the medical profession's willingness to assist in the maintenance of high standards of care to recipients under this program.

Your Reference Committee, therefore recommends the adoption of Resolution 5A/67, as amended by striking the words in the resolution that are bracketed. The author of this resolution concurs in the deletion of these words.

In closing, your Committee would like to express appreciation and thanks to those who helped in its deliberations and to the staff who assisted in the preparation of this report.

Respectfully submitted,
Everett S. Diggs, MD, *Chairman*
Howard F. Kinnamon, MD
Herbert H. Leighton, MD
DeWitt E. DeLawter, MD
Lawrence R. Wharton, Jr., MD

SUPPLEMENTAL REPORT OF THE TREASURER

Mr. President and Members of the House of Delegates:

The audited report of the financial affairs of the Faculty for the year 1966 and the 1967 budget are presented for your information and as a matter of record in accordance with the Bylaws. I am pleased to report that the Faculty is in sound financial condition.

Your particular attention is invited to the Restricted Fund Statement. These funds are controlled by your Treasurer with the assistance of the Finance Committee, which has submitted its own report to you.

There have been two substantial additions to the Faculty's Designated Funds since the date of these Financial Statements. The assets of the Walter Ralph Steiner Trust are being transferred to the Faculty as remainderman in the will of Dr. Steiner. The Fund will be known as the Lewis Henry Steiner Fund as the will directs, and the income from the fund may be used for the purchase of Library books and journals. Mrs. J. Mason Hundley, Jr., has added $3,000 to the J. Mason Hundley, MD, Lecture Fund with the request that the total fund be known as "The Hundley Memorial Lecture in Gynecology." We are very grateful to Mrs. Hundley and will comply with her request.

I shall be glad to answer any questions you might have.

Respectfully submitted,
Karl F. Mech, MD, *Treasurer*

TREASURER

Mr. President and Members of the House of Delegates:

The 1967 budget and the report on the affairs of the Medical and Chirurgical Faculty for the year of 1966 are presented for your information and as a matter of record in accordance with the Bylaws.

ESTIMATED EXPENDITURES
1967

	Budget 1966	Actual through November 1966	Budget 1967	
Auditing	$ 1,500.00	$ 1,337.80	$ 1,500.00	
Legal	4,000.00	3,866.74	5,000.00	
Contributions	600.00	550.00	700.00	A
Fuel	2,000.00	1,394.58	2,000.00	
Gas, Electricity, Water	5,000.00	4,190.59	5,000.00	
Telephone & Telegraph	4,800.00	3,930.47	4,800.00	
Postage	5,000.00	5,152.32	5,500.00	
Household & Janitorial	1,500.00	1,715.06	1,600.00	
Property Maintenance	2,500.00	3,225.33	2,500.00	
Insurance	2,000.00	1,358.16	2,000.00	
Equipment Rental	3,000.00	2,682.27	3,000.00	
New Equipment	2,000.00	840.24	8,500.00	
Equipment Maintenance	500.00	810.08	1,000.00	
Stationery & Supplies	4,000.00	2,895.28	4,000.00	
Salaries	145,255.00	129,882.66	153,698.00	B
Social Security	5,065.00	4,281.96	5,500.00	
Unemployment Compensation	2,600.00	886.63	2,000.00	
Employee's Insurance Program	3,400.00	2,282.65	3,000.00	
Employee's Pension Program	7,000.00	8,145.81	8,500.00	
Supplementary Hours	2,000.00	2,057.31	2,000.00	
Travel	6,000.00	4,552.40	6,000.00	C
Printing—Committees	2,000.00	4,261.10	2,000.00	
Printing—Gov'n Bodies	2,000.00	3,231.80	2,000.00	
Legislation	5,000.00	4,427.21	5,000.00	D
Library	4,310.00	2,363.73	5 000.00	E
Journal Expense	70,000.00	86,903.65	70,000.00	
Annual & Semiannual Meetings	21,000.00	22,476.14	21,000.00	
Miscellaneous Expenses	4,000.00	2,160.20	2,500.00	
Interest to Coggins Fund Presidential Fund	1,000.00	155.15	1,000.00	
Total	$324,530.00	$317,517.32	$341,798.00	

ESTIMATED INCOME
1967

	1966 Thru November		1967 Budget	
Dues				
B. C. M. S.	$104,287.50		$103,000.00	
Counties	107,410.00		107,000.00	
B. C. D. S.	1,955.00		2,000.00	
		$213,652.50		$212,000.00
Rents & Services				
B. C. M. S.	$ 24,548.00		$ 24,868.00	
Board of Medical Examiners	4,960.00		5,760.00	
Maryland League for Nursing	385.00		420.00	
Med-Chi Insurance Trust	10,023.00		10,772.00	
		$ 39,916.00		$ 41,820.00
Investments				
General Purpose		$ 4,209.68		$ 3,800.00
Medical Journal		$ 86,660.89		$ 70,000.00
Annual Meeting		$ 18,267.00		$ 15,000.00
Other		$ 6,564.92		$ 7,000.00
Total		$369,270.99		$350,620.00

EXPLANATORY NOTES ON 1967 PROPOSED BUDGET

Budgetary items for 1967 are predicated on actual cost for 1966. Only items where there is a substantial change will have explanatory notes.

A. Contributions:

National SAMA	$100.00
Student AMA, Maryland Chapter	250.00
National Society for Medical Research	50.00
Miscellaneous (Maryland League for Nursing)	300.00
	$700.00

B. Salaries:

Reflected in this figure are anticipated salary increments during 1967, plus offsetting amounts shown under receipts from Faculty's Insurance Trust and the Baltimore City Medical Society for services of its employees on Faculty payroll.

C. Travel:

The following items are budgeted for travel during 1967:

Professional Convention Management Association and Medical Exhibitors Association, Washington, D. C., January 9-12, 1967 One Staff Member

National Congress on Socio-Economics of Health Care, Chicago, Illinois, January 20-21, 1967 One Staff Member

Annual Medicolegal Conference, Miami, Florida, March 9-11, 1967 One Staff Member

Medical Society Executives Assn. (1 Day) and AMA Annual Meeting (5 Days), Atlantic City, N. J., June, 1967 One Staff Member, Three Delegates, Senior Alternate Delegate

Medical Society Executives Assn. (1 Day) and AMA Annual Institute (2 Days), Chicago, Illinois, August, 1967 Two Staff Members

American Medical Association House of Delegates (4 Days), Houston, Texas, December, 1967 One Staff Member, Three Delegates, Senior Alternate Delegate

Journal:

State Medical Journal Advertising Bureau Meeting, Chicago, Illinois, October, 1967 One Staff Member

American Medical Writers' Assn. Meeting, Chicago, October, 1967 One Staff Member

Library:

Advisory Board, Special Libraries Assn., Houston, Texas, January 18, 19, 20, 21, 1967 One Staff Member

Special Libraries Assn. Annual Meeting, New York, May 29-June 3, 1967 One Staff Member

Medical Library Association Meeting, Miami, Florida, June 5-9, 1967 One Staff Member

Regional Medical Library Assn., Washington, D. C., Fall, 1967 Two Staff Members

Any TRAVEL for which the Faculty is reimbursed by the AMA or other affiliated, allied or associated groups is approved without reference to the Executive Committee.

D. Legislative:

Operation of Legislative First Aid Room	$1,000.00
Distribution of Legislative Newsletter (5 issues)	2,000.00
Copies of legislation	200.00
Legislative Representatives expenses (Travel, meals, telephone, etc.)	500.00
Expenditure for Federal legislation	800.00
Legal services for preparation and analysis of proposed legislation	500.00
	$5,000.00

E. Library Expenses:

Total per Library Budget	$30,000.00
Less: Amount included in Salaries Account	25,000.00
Library Expense of General Fund	$5,000.00

Journal subscriptions, books, and binding are not included in above, but are purchased out of income from specific fund for Library purposes.

Light, heat, telephone, payroll taxes, etc., are also excluded.

Respectfully submitted,
KARL F. MECH, MD, Treasurer

BALANCE SHEET—DECEMBER 31, 1966

EXHIBIT A

ASSETS

General Fund

Cash

Maryland National Bank

Regular Checking	115.62	
Payroll	1,939.34	
Savings Accounts (Including $70,000.00 in Transit)	72,536.81	
Petty Cash Funds	400.00	74,991.77
Loyola Federal Savings and Loan Association—Hundley Fund—See Designated—Contra		3,061.39
Baltimore Federal Savings and Loan Association—Pension Fund—See Designated Contra		1,915.55
		79,968.71

Accounts Receivable

Dues, Journals, Subscriptions, etc.	21,560.66	
Faculty Insurance Program—Fees and Related Expenses	4,835.42	
	26,396.08	

Due from Other Funds

Consolidated Fund—Income Account	757.54	
Educational Fund	768.58	
	1,526.12	27,922.20
Loan Receivable—Plant Fund—Contra		30,000.00

Deferred Charges

Air Travel	425.00	
Annual Meeting	250.00	
Insurance Premiums	1,889.19	2,564.19
Total General Fund Assets		140,455.10

Endowment and Other Special Funds

Consolidated Fund—Exhibit A-1

Income Account	37,572.92	
Principal Account	211,137.55	248,710.47

Funded Reserve—Exhibit A-2

Income Account	1,990.69	
Principal Account	13,411.02	15,401.71

Harvey G. Beck—Lectureship Fund—Exhibit A-3

Income Account	960.85	
Principal Account	2,079.10	3,039.95

LIABILITIES AND CAPITAL

General Fund

Liabilities

Accounts Payable—Trade	2,298.70	
—AMERF Contributions	50.00	
—Plant Fund—Contra	30.00	
—County Medical Societies—Dues	53.50	2,432.20

Payroll Taxes

Withholding

United States—December, 1966	1,681.66	
State of Maryland—Fourth Quarter, 1966	872.42	
City of Baltimore—Fourth Quarter, 1966	270.30	
Old Age Benefit Tax—December, 1966	712.99	

Unemployment Insurance

United States—1966	329.08	
State of Maryland—Fourth Quarter, 1966	52.51	3,918.96

Designated Funds

For—Library Account—Books and Journals	2,772.61	
—The J. Mason Hundley Memorial Fund—On Deposit—Contra	3,061.39	5,834.00
Reserve for Pension Fund—On Deposit—Contra		1,915.55
Deferred Income—1967 Dues		4,755.00
Surplus—Exhibit C		121,599.39
Total General Fund—Liabilities, Reserves and Capital		140,455.10

Endowment and Other Special Funds

Consolidated Fund—Exhibit A-1

Income Account

Due General Fund	757.54		
Capital—Exhibit E	36,815.38	37,572.92	

Principal Account

Capital—Exhibit G		211,137.55	248,710.47

Funded Reserve—Exhibits A-2 and H

Income Account

Capital		1,990.69	

Principal Account

Due Income Account	480.34		
Capital	12,930.68	13,411.02	15,401.71

Jesse C. Coggins—Lectureship Fund			
Cash—Maryland National Bank			5,290.21
Jesse C. Coggins—New Building Fund—Exhibit A-4			
Income Account		32,802.26	
Principal Account		102,000.00	134,802.26
George M. Boyer—Lectureship Fund			
Cash—Loyola Federal Savings and Loan Association			5,081.85
Amos Koontz Memorial Fund—Exhibit A-5			
Principal Account			2,549.31
Educational Fund			
Cash—Maryland National Bank			94,430.88
Medical Annals Fund			
Cash—Union Trust Company of Maryland			1,230.39
Henry P. Laughlin, M.D.—Special Award Fund			
Cash—Loyola Federal Savings and Loan Association			97.69
Total Endowment and Other Special Funds			510,634.72
Plant Fund			
Cash—Maryland National Bank			7,464.69
Account Receivable—General Fund—Contra			30.00
Fixed Assets (No Depreciation Provided)			
1215-1217 Cathedral Street—Land—Cost.		19,118.95	
1209-1215 Cathedral Street			
Land and Building—Cost	110,635.76		
Improvements—Cost	331,525.47	442,161.23	
**Personal Property*			
Library Books and Journals	231,370.00		
Office, Library, Fixtures, Antiques and Museum Pieces	77,349.48		
Portraits	65,000.00	373,719.48	834,999.66
			842,494.35
Grand Total—All Funds			1,493,584.17

Harvey G. Beck—Lectureship Fund—Exhibits A-3 and J			
Income Account			
Capital		960.85	
Principal Account			
Capital		2,079.10	3,039.95
Jesse C. Coggins—Lectureship Fund			
Capital—Exhibit K			5,290.21
Jesse C. Coggins—New Building Fund—Exhibit A-4			
Income Account			
Liability			
Due Principal Account	13,916.98		
Capital	18,885.28	32,802.26	
Principal Account			
Capital		102,000.00	134,802.26
George M. Boyer—Lectureship Fund			
Capital			5,081.85
Amos Koontz Memorial Fund—Exhibit A-5			
Capital			2,549.31
Educational Fund			
Liability			
Due General Fund		768.58	
Capital—Exhibit M		93,662.30	94,430.88
Medical Annals Fund			
Capital—Exhibit I			1,230.39
Henry P. Laughlin, M.D.—Special Award Fund			
Capital			97.69
Total Endowment and Other Special Funds			510,634.72
Plant Fund			
Liabilities			
Jesse C. Coggins—New Building Fund		88,833.02	
General Fund—Contra		30,000.00	118,833.02
Capital—Exhibit N			723,661.33
Total Plant Fund Liabilities and Capital			842,494.35
Grand Total—All Funds			1,493,584.17

*The appraised value of portraits as of December 31, 1963 was $65,000.00, an increase of $51,000.00 over prior years. All other Personal Property appraised as of December 31, 1949, with subsequent additions at cost.

THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND
BALTIMORE, MARYLAND

STATEMENT OF INCOME, EXPENSES AND TRANSFERS
For the Year Ended December 31, 1966

EXHIBIT B

GENERAL FUND

Income			
Dues—Baltimore City Dental Society	1,955.00		
—Baltimore City Medical Society	104,287.50		
—County Medical Society	107,485.00	213,727.50	
Rents and Services			
Baltimore City Medical Society	24,548.00		
Others	6,285.00	30,833.00	
Meetings—Annual and Semi-Annual Exhibits		18,267.00	
Journal—Advertising	92,123.77		
—Subscriptions	645.04	92,768.81	
Addressograph Service		463.45	
Interest on Savings Accounts		4,942.95	
Miscellaneous		3,271.84	
		364,274.55	
Transfers from Consolidated Fund—Income for General Purposes—Exhibit F		4,564.41	
Total Income			368,838.96
Expenses			
Accounting Fees		1,337.80	
Communications Expense—Postage, Telephone and Telegraph		10,033.10	
Contribution		550.00	
Equipment Rental and Maintenance		3,934.83	
Fuel		1,394.58	
Gas, Electricity and Water		4,490.64	
Household and Janitorial Services		1,871.57	
Insurance—General		1,488.62	
—Hospitalization		2,613.81	
Journal Expense—Printing and Commissions		93,849.39	
Legal Fees		4,050.20	
Legislative		4,751.01	
Property Maintenance		3,322.16	
Meetings—Annual and Semi-Annual		22,556.89	
Office Supplies		4,392.13	
Purchases of Equipment		4,750.24	
Pension and Major Medical Contribution		8,511.25	
Printing—Governing Bodies		3,817.60	
Printing—Committees		4,355.25	
Salaries		132,109.07	
Social Security Tax—Employer's Portion		5,010.40	
Unemployment Insurance—United States		329.08	
—State of Maryland		939.14	
Travel		5,917.06	
Supplementary Hours		2,303.16	
Library		3,169.11	
Interest—Coggins Fund		5,500.00	
Presidential Fund		155.15	
Miscellaneous		2,556.22	
Total Expenses			340,059.46
Excess of Income Over Expenses—To Exhibit C			28,779.50

STATEMENT OF SURPLUS
For Year Ended December 31, 1966

EXHIBIT C

GENERAL FUND

January 1, 1966—Balance	92,819.89
Addition	
Excess of Income Over Expenses—For the Year Ended December 31, 1966—Exhibit B	28,779.50
December 31, 1966—Balance—To Exhibit A	121,599.39

BALANCE SHEET—DECEMBER 31, 1966
CONSOLIDATED FUND

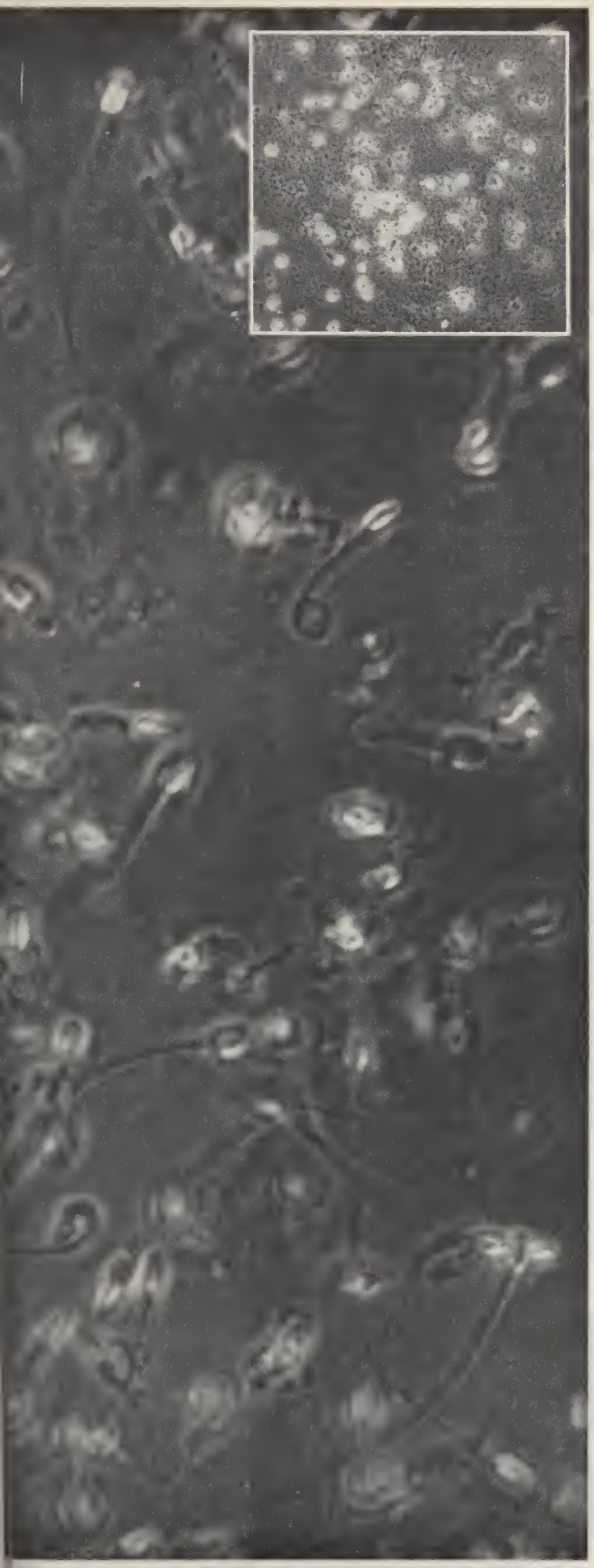
EXHIBIT A-1

ASSETS

Income Account			
Cash—*The Savings Bank of Baltimore*—Exhibit F			
Eugene Cordell Fund		10,788.21	
Special Account		16,182.95	26,971.16
Dividends Receivable—Held by Maryland National Bank—Exhibit F		1,704.13	
Investments			
Eugene Cordell Fund—Held by			
Maryland National Bank—Agent—Exhibit F			
Cash	299.09		
Common Stocks	8,598.54	8,897.63	
Total Income Account Assets—To Exhibit A			37,572.92
Principal Account			
Held by Maryland National Bank—Agent			
Cash—Overdraft		—278.54	
Investments—At Cost			
United States Government and Municipal Bonds	28,830.00		
Public Utilities and Railroads, etc.—Bonds	66,830.69		
Stocks—Preferred	7,679.17		
—Common	108,076.23	211,416.09	
Total Principal Account Assets—To Exhibit A			211,137.55
Grand Total—Income and Principal Accounts Assets—To Exhibit A			248,710.47

LIABILITY AND CAPITAL

Income Account—To Exhibit A	
Liability	
Due General Fund	
For Expenditures for the Year Ended December 31, 1966—Exhibits A and F	757.54
Capital—Exhibit E	36,815.38
Total Income Account Liability and Capital	37,572.92
Principal Account—To Exhibit A	
Capital—Exhibit G	211,137.55
Grand Total—Income and Principal Accounts—Liability and Capital—To Exhibit A	248,710.47



New view of an oral contraceptive at work

Although suppression of ovulation remains the primary mode of action of oral contraceptives, newer knowledge indicates that products like Norinyl-1—which provide the combined action of both low-dosage progestogen and estrogen for the full treatment cycle—offer multiple contraceptive action that helps explain their unexcelled record of effectiveness. This report explores the secondary protective mechanisms against unwanted pregnancy offered by combined hormonal administration and the importance of the progestational agent in making such multiple contraceptive action possible.

Accumulating evidence has indicated that sparse, highly viscous cervical mucus has an adverse effect on the motility and survival of spermatozoa.

The estrogen-opposing progestational ingredient of Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.) reverses the usual midcycle picture of a thin, watery cervical mucus. The result—a built-in barrier that inhibits sperm from reaching the ovum should one be released. The inset in the adjoining photograph shows immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

See last page for contraindications, precautions, side effects and dosage.

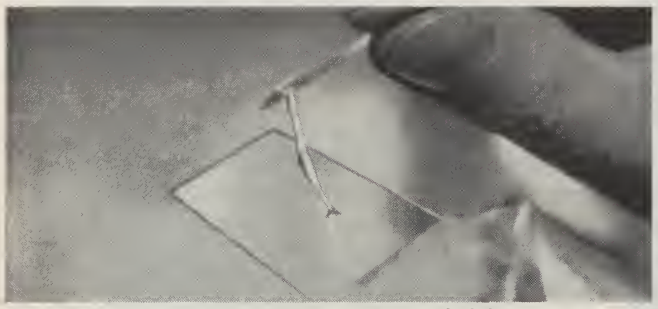
How the estrogen-opposing action of Norinyl-1 creates a hostile cervical mucus

Normally estrogen activity during the fertile midcycle stimulates the production of cervical mucus. The mucus at this time is profuse and watery—allowing maximum sperm motility and promoting penetration.
But what happens when Norinyl-1 is administered? Its potent progestogen, norethindrone, opposes estrogen stimulation of cervical mucus. Consequently, the amount of mucus decreases and its viscosity increases. This results in a sparse but thick mucus barrier that diminishes the vitality of the sperm and impairs its powers of penetration.

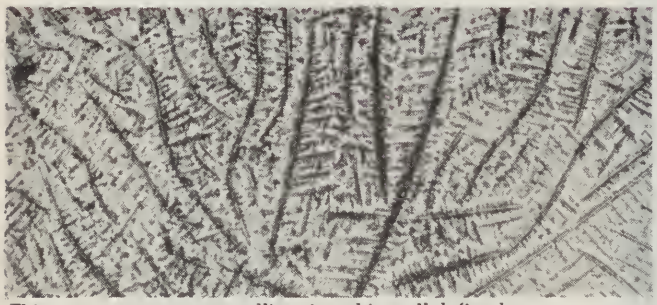
How hostile cervical mucus supports contraceptive action

The importance of these observations to the effectiveness of Norinyl-1 has been noted in a report on 89 patients taking this medication.* In all instances, cervical mucus obtained from cycle day 5 to cycle day 29 appeared scant and thick and exhibited little or no Spinnbarkeit. In the opinion of this investigator, the effect on cervical mucus may be sufficient to prevent conception. *Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965.

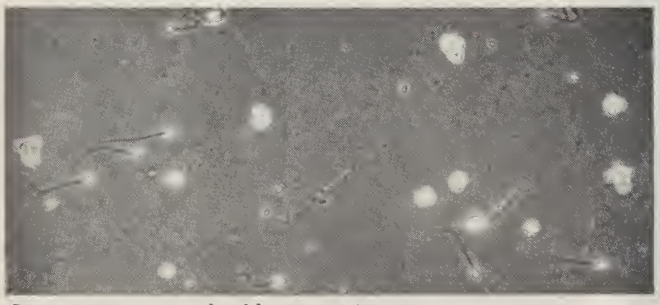
Normal cervical mucus at midcycle in untreated patient permits sperm motility... promotes sperm penetration.



Cervical mucus is thin and watery with a stretchability (Spinnbarkeit) of 15 to 20 cm.

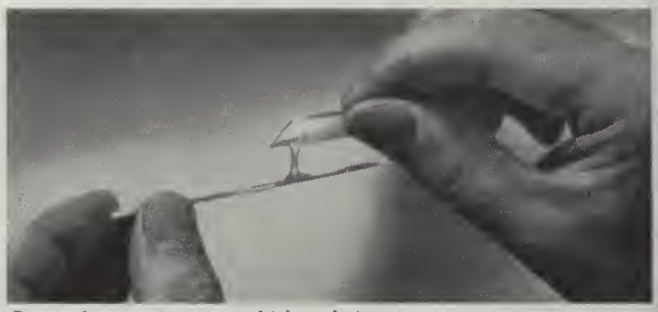


Thin, watery mucus crystallizes into this well-defined, fernlike pattern within a minute.

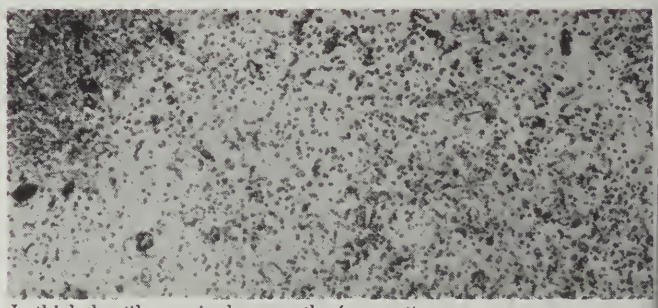


Spermatozoa appear healthy, are active and free moving.

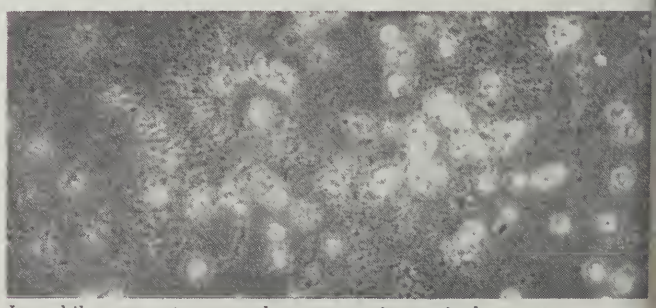
Hostile cervical mucus at midcycle produced by Norinyl-1 impairs sperm vitality... inhibits penetration.



Cervical mucus is scanty, thick and viscous. Spinnbarkeit is 1 cm. or less.



In thick, hostile cervical mucus the fern pattern is poorly defined or absent.

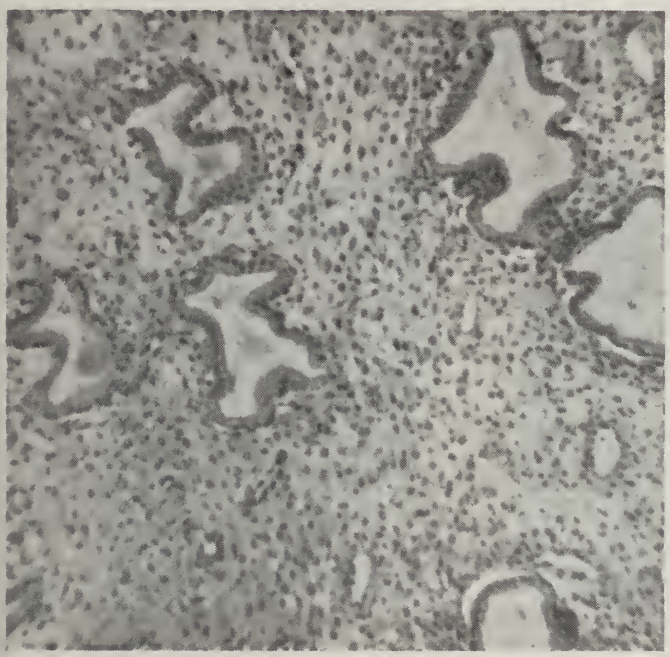


Immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

An endometrium unreceptive to nidation– another supporting contraceptive action of Norinyl-1

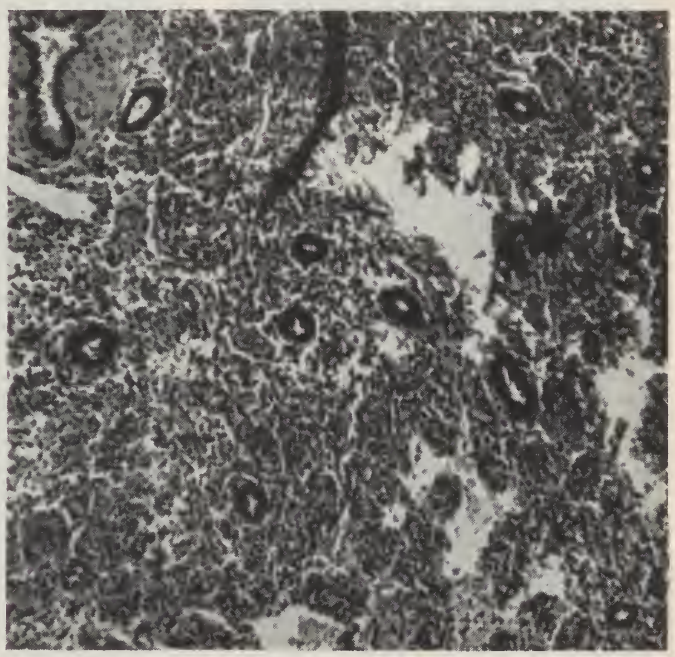
Let us suppose that an ovum is released—as occurs in an occasional, rare case—and somehow a sperm succeeds in penetrating the cervical mucus barrier? Should this come about, one additional action of Norinyl-1 may protect the patient from unwanted pregnancy—progestogen intake makes endometrial tissue unreceptive to implantation.

Endometrium of untreated patient



Normally the endometrium progresses through a proliferative phase stimulated by estrogen and a secretory phase stimulated by progesterone. During the secretory phase the endometrium is receptive to the fertilized ovum.

Unreceptive endometrium produced by Norinyl-1



When Norinyl-1 is administered its progestogen component—norethindrone—accelerates the secretory phase, suppressing glandular development. From day 11 on, secretory action is no longer present. The result is that during the latter half of the cycle the endometrium becomes unreceptive to egg implantation.

new Norinyl®-1 tablets

(norethindrone 1mg c mestranol 0.05mg.)

See last page for contraindications, precautions, side effects and dosage.

for multiple contraceptive action

effective fertility control
on half the previous dosage

maintains ratio
of the established
norethindrone/mestranol
combination

lower cost

new Norinyl®-1 tablets

(norethindrone 1mg. c̄ mestranol 0.05mg.)

Reduction of oral contraceptive dosage to lowest effective levels has become a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now available in a new strength in which *both* norethindrone and mestranol are reduced 50 percent. Studies show that Norinyl-1 achieves fertility control with only 1.05 mg. of combined progestogen and estrogen per tablet.

Norethindrone was first reported for use as a progestational agent in human beings in 1955. Norethindrone 2 mg. with mestranol 0.1 mg., as an oral contraceptive, is currently in use by over 2,000,000 women. Clinical experience now establishes that Norinyl-1 also amply meets the criteria of reliability and safety.*

*Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965.

PRESCRIBING INFORMATION

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of Norinyl-1 in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with Norinyl-1. Therefore, if such tests are abnormal in a patient taking Norinyl-1, it is recommended that they be repeated after the drug has been withdrawn for 2 months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibroids may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac, or renal dysfunction, require careful observation. 5. Although a cause and effect relationship has not been established, Norinyl-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, as in all cases of irregular bleeding *per vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged Norinyl-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Norinyl-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. A cause and effect relationship has not been demonstrated. 11. Because of the effects of estrogens on epiphyseal closure, Norinyl-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask the onset of the climacteric. 13. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma, breast changes (tenderness, enlargement and secretion), loss of scalp hair, change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, erythema multiforme, erythema nodosum, hemorrhagic eruption, migraine, rash (allergic), itching, rise in blood pressure in susceptible individuals, mental depression.

The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has not been established: thrombophlebitis, pulmonary embolism, neurooocular lesions.

The following laboratory results may be altered by the use of oral contraceptives: increased bromsulphalein retention and other hepatic function tests, coagulation tests (increase in prothrombin, factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metapyrone test, pregnanediol determination.

Other side effects reported to have occurred in association with use of this drug are dizziness, hirsutism, pains in legs, back, chest and abdomen, dysuria, drowsiness, vaginal discharge, libido increased and decreased, eruptions, hypermenorrhea, hypomenorrhea, increased appetite, G.U. infections, varicose veins, abdominal fullness, acne, headache, nervousness, allergies, blurred vision, pain in eyes, and itching in eyes. *For complete clinical data, see package insert.*

Dosage and Administration: 1. One tablet of Norinyl-1 is administered orally for 20 days beginning on day 5 of the menstrual cycle. (Count day 1 of the cycle as the first day of menstrual bleeding.) Repeat this dosage schedule for each cycle. 2. If no menstrual period occurs after a cycle of treatment (20 tablets) in which patient adhered to the schedule, the patient must be instructed to resume taking the Norinyl-1 tablets 7 days after the previous 20 day course was completed. For example, if the last pill of a previous cycle had been taken on a Sunday, then a new cycle of treatment should begin on the following Sunday. 3. In the postpartum woman, it is recommended that the first cycle of treatment should begin on day 5 of the first menstrual cycle. However, Norinyl-1 should not be administered during lactation.

Availability: Norinyl-1 (norethindrone 1 mg with mestranol 0.05 mg.)—Dispensers of 20 and 60 and bottles of 250 tablets.

norethindrone — an original steroid from

SYNTEX LABORATORIES INC., PALO ALTO, CALIF.

In Maryland . . .
These Syntex men serve the physician



Michael Catena
Pittsburgh, Pennsylvania
653-5948



Anthony Chirgott
Baltimore, Maryland
488-0742



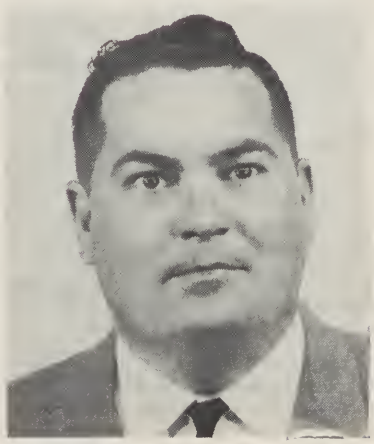
Wayne Ettare
Falls Church, Virginia
534-3520



John Mullikin
Queenstown, Maryland
827-8217



David Mathews
Glen Burnie, Maryland
761-0381



Arnold Pelter
Baltimore, Maryland
282-3553

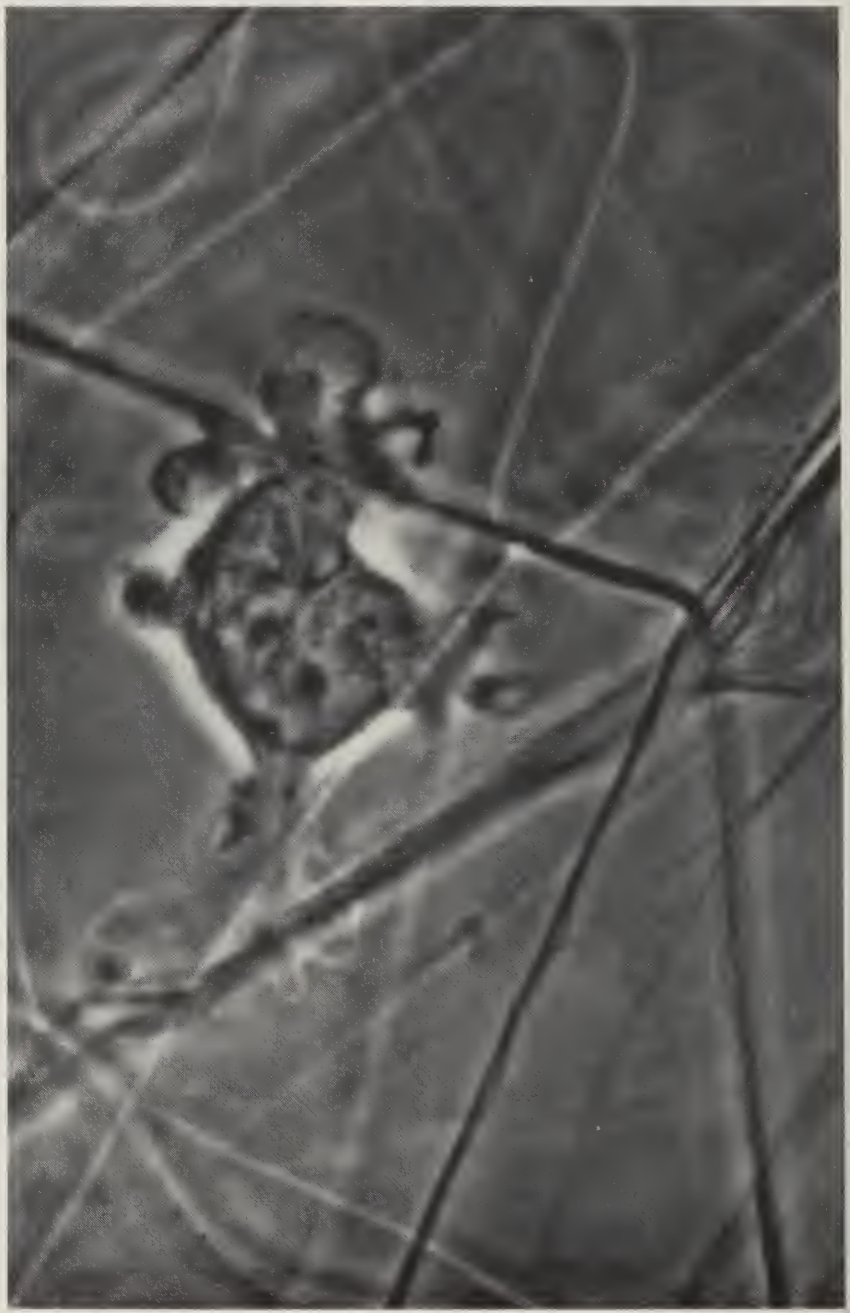
SYNTEX
LABORATORIES INC. PALO ALTO, CALIF

INFLAMMATION:
A cellular fight for life

A SYNTEX REPORT based on recently developed hypotheses about topical corticosteroids, including the cellular theories of inflammation by Thomas F. Dougherty, Ph.D., University of Utah.

You are looking at a fibroblast fighting for life. This cell—one of the most common found in connective tissue—has literally been poisoned by cytotoxins released from other cells that have ruptured. Soon, if the abnormal activity of this fibroblast does not cease, it, too, will rupture and die—one more casualty in the inflammatory wave of destruction precipitated by injury.

Until a short time ago no one had ever witnessed such a scene at the cellular level. Now, through advanced cinemicrographic techniques, it is possible to view and photograph the inflammatory process as produced experimentally in living animal tissue. This method permits new insight into the mechanism of inflammation and the role of corticosteroids in therapeutic management. Equally important, these techniques shed new light on factors that may make one corticosteroid more effective than another—factors that can be correlated with other chemical, biologic, and clinical parameters.

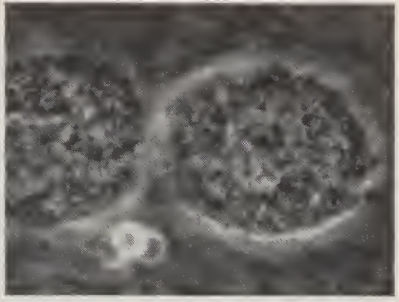


Visual evidence of how corticosteroids influence the inflammatory reaction

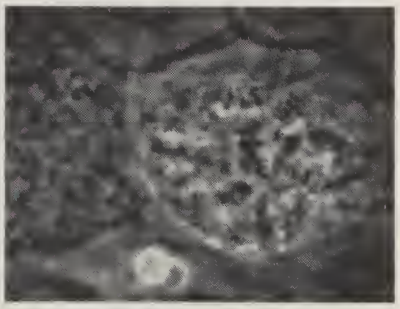
Working with phase-contrast cinemicrography on living animal tissue, Doctors Thomas F. Dougherty and David Berliner of the University of Utah College of Medicine have actually filmed cellular events that occur during the inflammatory reaction. This remarkable study* and additional work by these investigators, as well as by others, have established a new theoretical biologic basis for the antiinflammatory effect of the corticosteroids. (It must be noted that other theories, such as the lysosome or so-called "suicide bag" theory, have been postulated, although it is quite likely that there are more similarities than differences among the various theoretical models.)

The inflammatory wave of destruction

In this investigation an injurious injection of gelatin is used to set off an inflammatory reaction in living mouse tissue. What follows is a wave of destructive cellular activity that comprises the inflammatory response to injury. Mast cells (which contain heparin, serotonin and histamine) take up water, swell and rupture, releasing their contents, which are toxic outside the mast cell wall. These toxins, in turn, cause disintegration of other cells (such as fibroblasts) and the release of additional toxic material. Capillaries, too, take up water and leak unformed blood elements, causing edema. And polymorphonuclears, lymphocytes and perithelial cells invade the inflamed site. As a result of all these changes, the cellular environment reaches a state of turmoil.



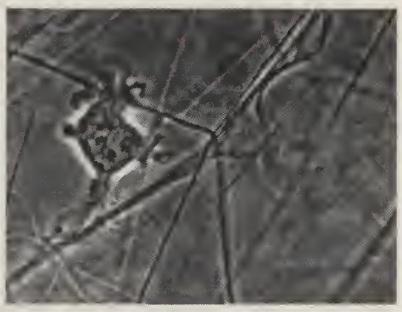
Phase-contrast microscopy showing mast cell before injury.



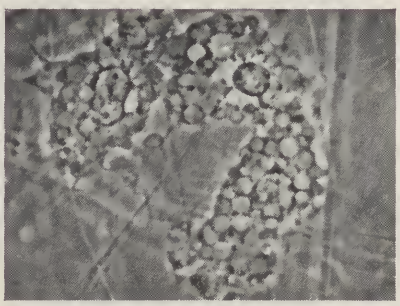
Mast cell (after injury) has broken up and released cytotoxins.

How corticosteroids change the picture

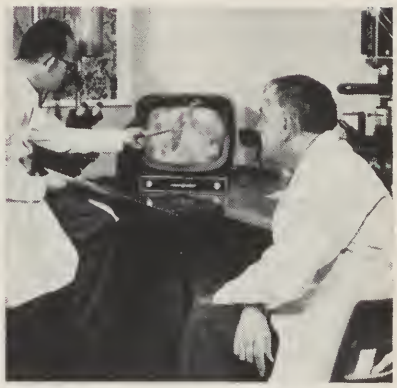
Corticosteroids appear to virtually stop the abnormal cellular activity that constitutes the inflammatory reaction. This permits the body's natural resources to clear up the inflamed area and repair the damaged tissue. This interpretation is supported by the fact that when the injurious gelatin solution is injected simultaneously with a corticosteroid – Synalar (fluocinolone acetonide) – the inflammatory pattern simply does not develop.



Fibroblast in high state of activity, much distorted.



Mast cells showing effects of corticosteroid action: cells are normal in size, shape and activity.



In summarizing his study Doctor Dougherty states: "...we also feel this work may explain why one corticosteroid helps a patient more rapidly and effectively than another. If it does, it is because one corticosteroid is the fastest, most effective inhibitor of the series of inflammatory events at the tissue level."

A New View of Corticosteroid Action in Inflammatory Dermatoses, a film based on this study, is now available from your Syntex representative.

See last page for contraindications, precautions, side effects and dosage.

Worldwide clinical experience confirms the predictable therapeutic potential of Synalar

It is particularly gratifying that the promise of the advanced chemical design and high order of bioassay activity of Synalar (fluocinolone acetonide) has been confirmed by widespread therapeutic application. Indeed, the impressive clinical response rate of Synalar has been documented in no fewer than 232 papers from 22 countries.

Representative Clinical Results with Synalar*

Efficacy Documented in over 4,000 Patients

Condition	Number of Publications	Number of Patients	Significant Improvement†
Contact Dermatitis	27	750	713
Eczematous Dermatitis	21	472	409
Seborrheic Dermatitis	18	442	426
Atopic Dermatitis	24	460	426
Psoriasis	36	1,699	1,510
Neurodermatitis	18	351	324
Total	144	4,174	3,808

*Complete bibliography on request.

†Expressed by the authors as excellent, very good, good, complete remission of inflammation, etc.

PRESCRIBING INFORMATION

For initiation of therapy: Cream 0.025%, 5 and 15 Gm. tubes, 425 Gm. jars; *for emollient effect:* Ointment 0.025%, 15 Gm. tubes; *for maintenance therapy:* Cream 0.01%, 15 and 45 Gm. tubes, 120 Gm. jars; *for intertriginous or hairy sites:* Solution 0.01%, 20 cc. and 60 cc. plastic squeeze bottles; *for infected inflammatory dermatoses:* Neo-Synalar® Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes.

CONTRAINDICATIONS: Tuberculous, fungal, and most viral lesions of the skin, (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. PRECAUTIONS: Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. When severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. SIDE EFFECTS: Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. The neomycin in Neo-Synalar Cream rarely produces allergic reactions.

REFERENCES: 1. Lerner, L. J., Bianchi, A., Turkheimer, A. R., Singer, F. M., and Borman, A.: Anti-inflammatory steroids: potency, duration and modification of activities. Ann NY Acad Sci 116:1071 (Aug. 27) 1964. 2. Idem: Comparison of anti-granuloma, thymolytic and glucocorticoid activities of anti-inflammatory steroids. Proc Soc Exp Biol Med 116:385 (June) 1964. 3. Ringler, A.: Activities of adrenocorticosteroids in experimental animals and man, in Dorfman, R. I.: Methods of hormone research, New York, Academic Press, 1964. vol. III. pp. 234-280. 4. Gubersky, V. R.: To be published.

fluocinolone acetonide — an original steroid from

SYNTEX LABORATORIES INC., PALO ALTO, CALIF.

For inflammatory dermatoses... by any measure a topical corticosteroid of choice

Synalar® (fluocinolone acetonide)

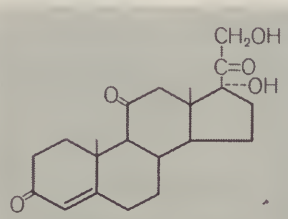
Milligram for milligram one of the most active topical corticosteroids available

Rapid and predictable in antiinflammatory and antipruritic activity

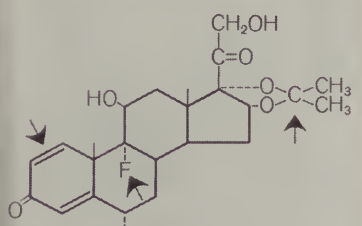
Results often comparable to those of systemic corticosteroids with fewer hazards

How advances in chemical design have achieved greater steroid potency

The chemical modification of corticosteroid molecules from the advent of hydrocortisone to the development of Synalar (fluocinolone acetonide) is a prime example of how biochemists can "design" to increase therapeutic activity and minimize undesirable side actions. Below, for example, we see the important changes that were made in reference to the hydrocortisone molecule to produce fluocinolone acetonide, one of the most active of all topical corticosteroids. As a result, a 0.01% preparation of Synalar (fluocinolone acetonide) has been reported to do the work of a 1% hydrocortisone product containing 100 times more cortiscosteroid. And it can often do it more effectively.



Hydrocortisone

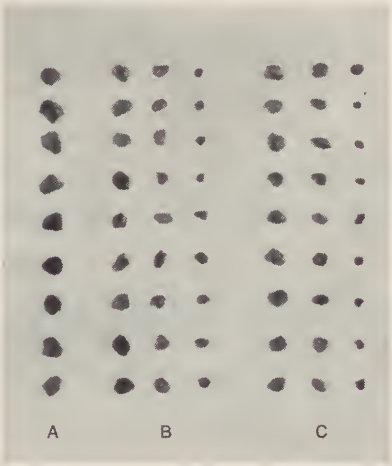


Fluocinolone Acetonide (Synalar)

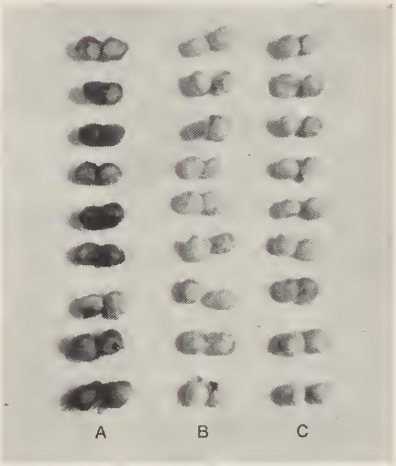
- *a double bond between carbons 1 and 2*
- *fluorine substitutions at* both *the 6-α, and the 9-α positions*
- *the addition of the acetonide at the 16-α, 17-α positions, thus providing one of the most potent topical corticosteroids available.*

How bioassay tests are used to "predict" therapeutic potential

Biologic assays are another tool used by researchers to help establish the relative activity of corticosteroids. To date no single method of assaying corticosteroid activity has emerged as the ideal "yardstick" for predicting therapeutic potential. Taken together, however, these methods have proved useful. When such tests are run on various corticosteroids, a definite order of corticosteroid activity becomes evident. Compounds with the highest order of activity may be expected to merit clinical trial to establish their high therapeutic potential. When assayed by these methods, fluocinolone acetonide (Synalar) emerges as one of the most active topical corticosteroids, milligram for milligram, available for clinical application today.



THE THYMUS INVOLUTION ASSAY[1-4] is run on adrenalectomized rats. The sizes of the glands are measured, and the degree of involution caused by the steroid is determined as an indication of its potency. In the above photo, the comparative involution of thymus glands achieved with hydrocortisone and Synalar (fluocinolone acetonide) is shown. Untreated controls (A) show normal size. Group B—injected with 1, 2 and 4 mg. of hydrocortisone—show progressively smaller thymuses as does Group C—injected with fluocinolone acetonide—but with only 1/500th the dose of hydrocortisone.



THE ANTIGRANULOMA ASSAY[1-4] also utilizes adrenalectomized rats. Granulomas are induced by subcutaneous implantation of cotton pellets on either side of the thorax. The degree of granuloma inhibition achieved by a steroid reflects its potency. The above photo shows the inhibition of granuloma formation achieved with hydrocortisone and Synalar (fluocinolone acetonide). Untreated controls (A) show large, red granulomas adhering to the pellets. Group B, receiving hydrocortisone and Group C, receiving fluocinolone acetonide, show little, if any, granuloma formation. Fluocinolone acetonide produced the same effect as hydrocortisone with only 1/500th the dose. This assay, as well as the thymus involution assay, measures systemic rather than topical corticosteroid activity. Nevertheless, results by these methods correlate well with other assays and with the milligram potencies of topical steroids in current clinical use.

BALANCE SHEET—DECEMBER 31, 1966 EXHIBIT A-2
FUNDED RESERVE

ASSETS

Income Account			
Cash—Savings Bank of Baltimore		1,510.35	
Due from Principal Account—Contra		480.34	
Total Income Account Assets—To Exhibit A			1,990.69
Principal Account			
Investments—Funded Reserve—Held by Maryland National Bank—Agent			
Cash		178.71	
United States Government Bonds	2,284.38		
Common Stocks	10,947.93	13,232.31	
Total Principal Account Assets—To Exhibit A			13,411.02
Grand Total—Income and Principal Account Assets—To Exhibit A			15,401.71

LIABILITY AND CAPITAL

Income Account—To Exhibit A			
Capital—Exhibit H			1,990.69
Principal Account—To Exhibit A			
Liability			
Due Income Account—Contra		480.34	
Capital—Exhibit H		12,930.68	
Total Principal Account Liability and Capital—To Exhibit A			13,411.02
Grand Total—Income and Principal Accounts—Liability and Capital—To Exhibit A			15,401.71

BALANCE SHEET—DECEMBER 31, 1966 EXHIBIT A-3
HARVEY G. BECK—LECTURESHIP FUND

ASSETS

Income Account			
Cash—Savings Bank of Baltimore—To Exhibit A			960.85
Principal Account			
Investments—Held by Maryland National Bank—Agent			
Cash		109.36	
Common Stock		1,969.74	
Total Principal Account Assets—To Exhibit A			2,079.10
Grand Total—Income and Principal Accounts Assets—To Exhibit A			3,039.95

LIABILITY AND CAPITAL

Income Account			
Liability			None
Capital—Exhibit J			960.85
Total Income Account Capital—To Exhibit A			960.85
Principal Account—To Exhibit A			
Capital—Exhibit J			2,079.10
Grand Total—Income and Principal Accounts Capital—To Exhibit A			3,039.95

BALANCE SHEET—DECEMBER 31, 1966 EXHIBIT A-4

JESSE C. COGGINS—NEW BUILDING FUND

ASSETS

Income Account		
Cash—Loyola Federal Savings and Loan Association	32,052.26	
Accrued Interest on Principal Account Investments	750.00	
Total Income Account Assets—To Exhibit A		32,802.26
Principal Account		
Accounts Receivable		
Due from Plant Fund	88,083.02	
Due from Income Account—Contra	13,916.98	
Total Principal Account Assets—To Exhibit A		102,000.00
Grand Total—Income and Principal Accounts Assets—To Exhibit A		134,802.26

LIABILITY AND CAPITAL

Income Account—To Exhibit A		
Liability		
Due to Principal Account—Contra	13,916.98	
Capital (Includes $6,650.30 of Interest Earned During Year)	18,885.28	
Total Income Account Liability and Capital		32,802.26
Principal Account—To Exhibit A		
Capital		102,000.00
Grand Total—Income and Principal Accounts Liability and Capital—To Exhibit A		134,802.26

BALANCE SHEET—DECEMBER 31, 1966 EXHIBIT A-5

AMOS KOONTZ MEMORIAL FUND

ASSETS

Principal Account	
Cash—Loyola Federal Savings and Loan Association	2,549.31
Total Principal Account Asset—To Exhibit A	2,549.31

LIABILITY AND CAPITAL

Principal Account	
Liability	None
Capital—Exhibit L	2,549.31
Total Principal Capital—To Exhibit A	2,549.31

STATEMENT OF INCOME, EXPENSES AND APPROPRIATIONS

EXHIBIT D

For Year Ended December 31, 1966

CONSOLIDATED FUND—INCOME ACCOUNT

Income			
Investments—General			
Bonds			
United States Government and Municipals	970.00		
Public Utilities, Railroads, etc.	2,862.95	3,832.95	
Stocks			
Preferred	358.82		
Common	13,226.29	13,585.11	
Interest on Special Savings Account—The Savings Bank of Baltimore		970.27	
		18,388.33	
Less—Agency Fees	846.72		
—Broker's Fees	1,039.82	1,886.54	
		16,501.79	
Transfer from Special Savings Account		1.00	
Net Income—Exhibit F		16,502.79	
Investments—Eugene F. Cordell Fund—Exhibit F			
Stocks			
Common	428.00		
Less—Agency Fee	25.68	402.32	16,905.11
Interest on Savings Account—The Savings Bank of Baltimore—Exhibit F			369.08
			17,301.19
Expenses and Appropriations—Exhibit F			
Library Purposes—General		6,870.28	
Library Payroll, Maintenance, etc.—General Fund		4,564.41	
Lectureship		465.96	11,900.65
Excess of Income Over Expenses and Transfers—To Exhibit E			5,400.54

STATEMENT OF CAPITAL

EXHIBIT E

For Year Ended December 31, 1966

CONSOLIDATED FUND—INCOME ACCOUNT

January 1, 1966—Balance—Exhibit F	31,414.84
Addition	
Excess of Income Over Expenses—For the Year Ended December 31, 1966—Exhibit D	5,400.54
December 31, 1966—Balance—To Exhibits A, A-1 and F	36,815.38

STATEMENT OF RECEIPTS, EXPENSES AND BALANCES

EXHIBIT F

For Year Ended December 31, 1966

CONSOLIDATED FUND—INCOME ACCOUNT

FUND	Distributive Share Per Cent	Balance January 1, 1966	INCOME RECEIVED DURING YEAR			Balance January 1 1966 Plus Receipts	EXPENSES			BALANCE DECEMBER 31, 1966	
			Savings Account Interest	INVESTMENT INCOME (Distributive Share)	INVESTMENT INCOME (Direct)		Library	Transferred to General Fund (Exhibit B)	Lectureship	Cash, Investments and Dividends Receivable	Cash on Deposit
Baker	.65	13.36		94.18		107.54	106.41			1.13	
Barker, Lewellys F.	.39	8.42		56.51		64.93	34.52			30.41	
Bowen, Josiah S.	9.17	175.36		1,328.58		1,503.94		1,347.67		156.27	
Bressler, Frank C.	1.80	34.23		260.79		295.02		264.35		30.67	
Cordell, Eugene Fauntleroy	3.64	18,491.30	396.08	527.38	402.32	19,817.08				19,817.08	10,788.21
Cowles, Nellie N.	.75	942.91		108.66		1,051.57	171.56			880.01	
Fllis, Charles M.	....	....	....	2,014.43		2,014.43		2,014.43		....	
Finney, John M. T	8.40	5,741.98		1,217.02		6,959.00	901.88		100.00	5,957.12	
Frick, William F.	15.02	286.60		2,176.15		2,462.75	2,206.79			255.96	
Friedenwald, Julius F.	.75	15.26		108.66		123.92		111.14		12.78	
Harlan, Herbert	.76	303.33		110.11		413.44	94.00			319.44	
McCleary Standish	.75	109.15		108.66		217.81	88.86		100.00	28.95	
Osler, Endowment	1.40	27.62		202.84		230.46	206.60			23.86	
Osler, Testimonial	7.75	3,533.70		1,122.85		4,656.55	958.91	495.39		3,202.25	
Ruhrah, John	40.79	−2,331.66		5,909.80		3,578.14	1,859.26			1,718.88	
Stokes, William Royal	3.09	557.32		447.69		1,005.01	241.49		140.00	623.52	
Trimble, Isaac Ridgeway	2.64	3,462.18		382.49		3,844.67			125.96	3,718.71	
Woods, Hiram	2.25	43.78		325.99		369.77		331.43		38.34	
	100.00	*31,414.84	396.08	16,502.79	402.32	48,716.03	6,870.28	4,564.41	465.96	*36,815.38	10,788.21

*To Exhibit E .....Totals to Exhibit D.....

.....Totals to Exhibit D..... *To Exhibit E To Summary

Summary—To Exhibit A-1

Cash		
Individual Accounts—Above...	$10,788.21	
Special Account	16,182.95	
Dividends Receivable	1,704.13	$28,675.29
Cordell Fund		
Cash	299.09	
Investments	8,598.54	8,897.63
Less—Accounts Payable to General Fund		757.54
		$36,815.38

STATEMENT OF CAPITAL
December 31, 1966

EXHIBIT G

CONSOLIDATED FUND— PRINCIPAL ACCOUNT

FUND	PURPOSE	BALANCE JANUARY 1, 1966	NET PROFIT ON SECURITY SALES	BALANCE DECEMBER 31, 1966
Baker	Book of Materia Medica	1,199.79	122.04	1,321.83
Barker, Lewellys F.	Library	719.89	73.22	793.11
Bowen, Josiah S.	General	16,884.70	1,721.73	18,606.43
Bressler, Frank C.	General	3,313.55	337.96	3,651.51
Cordell, Eugene Fauntleroy	Relief of Widows and Orphans	6,702.99	683.44	7,386.43
Cowles, Nellie N.	Books on Neurology	1,382.39	140.82	1,523.21
Ellis, Charles M.	General	8,258.46	....	8,258.46
Finney, John M. T.	Books, Journals and Lectureships on Surgery	15,456.36	1,577.16	17,033.52
Frick, William F.	Maintenance — Frick Library, Purchase Books and Journals	27,645.69	2,820.11	30,465.80
Friedenwald, D. Julius	Maintenance of Friedenwald Room	1,382.40	140.82	1,523.22
Harlan, Herbert	Books on Ophthalmology	1,402.71	142.70	1,545.41
McCleary, Standish	Lectureship and Books on Pathology	1,382.40	140.82	1,523.22
Osler—Endowment	Permanent Endowment for Library by Request of Dr. Osler	2,572.66	262.86	2,835.52
Osler—Testimonial	Medical Books and Maintenance of Osler Hall	14,262.70	1,455.12	15,717.82
Ruhrah, John	Library Books, Journals, etc.	75,086.62	7,658.61	82,745.23
Stokes, William Royal	Lectureships and Books on Bacteriology or Pathology	5,695.05	580.17	6,275.22
Trimble, Isaac Ridgeway	Lectureship Only	4,862.96	495.68	5,358.64
Woods, Hiram	General	4,150.52	422.45	4,572.97
		192,361.84	*18,775.71	*211,137.55

*To Schedule G-I

*To Exhibits A and A-1

STATEMENT OF SECURITIES SOLD
For Year Ended December 31, 1966

SCHEDULE G-1

CONSOLIDATED FUND—PRINCIPAL ACCOUNT

SHARES	DESCRIPTION	ACCOUNT RECEIVED	COST	GAIN
	COMMON STOCKS			
68	General Motors Corporation	4,989.86	724.04	4,265.82
300	Bethlehem Steel Corporation	8,621.64	480.64	8,141.00
168	Westinghouse Electric Corporation	8,336.51	2,005.00	6,331.51
	STOCK RIGHTS			
20	International Business Machines	37.38	....	37.38
		21,985.39	3,209.68	*18,775.71

*To Exhibit G

STATEMENT OF CAPITAL
For Year Ended December 31, 1966

EXHIBIT H

FUNDED RESERVE

INCOME ACCOUNT

January 1, 1966—Balance		1,280.49
Additions		
Dividends	641.80	
Interest—United States Government Bond	62.50	
—Savings Account	48.16	752.46
		2,032.95

Deduction

Agency Fee	42.26
December 31, 1966—Balance—To Exhibits A and A-2	1,990.69

PRINCIPAL ACCOUNT

January 1, 1966—Balance	12,930.68
No Changes during the Year Ended December 31, 1966	....
December 31, 1966—Balance—To Exhibits A and A-2	12,930.68

STATEMENT OF CAPITAL — EXHIBIT I
For Year Ended December 31, 1966

MEDICAL ANNALS FUND

January 1, 1966—Balance	1,185.79
Addition	
Interest on Savings Account	44.60
December 31, 1966—Balance—To Exhibit A	1,230.39

STATEMENT OF CAPITAL — EXHIBIT J
For Year Ended December 31, 1966

HARVEY G. BECK—LECTURESHIP FUND

INCOME ACCOUNT

January 1, 1966—Balance		867.92
Additions		
Dividends	180.40	
Interest—Savings Account	40.37	220.77
		1,088.69
Deductions		
Agency Fee	10.84	
Reimbursement to General Fund for Expenditures	117.00	127.84
December 31, 1966—Balance—To Exhibits A and A-3		960.85

PRINCIPAL ACCOUNT

January 1, 1966—Balance	2,079.10
No Changes during Year Ended December 31, 1966	....
December 31, 1966—Balance—To Exhibits A and A-3	2,079.10

STATEMENT OF CAPITAL — EXHIBIT K
For Year Ended December 31, 1966

JESSE C. COGGINS—LECTURESHIP FUND

January 1, 1966—Balance	5,204.41
Addition	
Interest—Savings Account	196.80
	5,401.21
Deduction	
Reimbursement to General Fund for Expenditures	111.00
December 31, 1966—Balance—To Exhibit A	5,290.21

STATEMENT OF CAPITAL — EXHIBIT L
For Year Ended December 31, 1966

AMOS KOONTZ MEMORIAL FUND

PRINCIPAL ACCOUNT

January 1, 1966—Balance		2,417.83
Additions		
Contributions Received during the year	25.00	
Interest on Savings Account	106.48	131.48
December 31, 1966—Balance—To Exhibit A-5		2,549.31

STATEMENT OF CAPITAL — EXHIBIT M
For Year Ended December 31, 1966

EDUCATIONAL FUND

PRINCIPAL ACCOUNT

January 1, 1966—Balance		70,944.52
Additions		
Investment Income	4,330.57	
Special Assessments	37,916.90	42,247.47
		113,191.99
Deductions		
Legislative, Public Relations and Educational Expenses	3,276.37	
Medic Network Expenditures	16,253.32	19,529.69
December 31, 1966—Balance—To Exhibit A		93,662.30

STATEMENT OF CAPITAL — EXHIBIT N
For Year Ended December 31, 1966

PLANT FUND

January 1, 1966—Balance	716,477.83
Addition	
Assessment	15,405.00
	731,882.83
Deduction	
Building—Painting and Repairs	8,221.50
December 31, 1966—Balance—To Exhibit A	723,661.33

THE MEDICAL AND CHIRURGICAL FACULTY
OF THE STATE OF MARYLAND,
1211 CATHEDRAL STREET,
BALTIMORE, MARYLAND 21201

March 27, 1967

CERTIFICATE

GENTLEMEN:

We have made an audit of the records of the Treasurer of the Medical and Chirurgical Faculty of the State of Maryland for the year ended December 31, 1966. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures that we considered necessary in the circumstances.

In our opinion, the Exhibits, together with the comments in this report, present fairly the financial position of the Faculty as of December 31, 1966 and the results from operations for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Respectfully submitted,
WOODEN, BENSON & WALTON

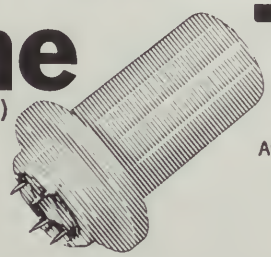
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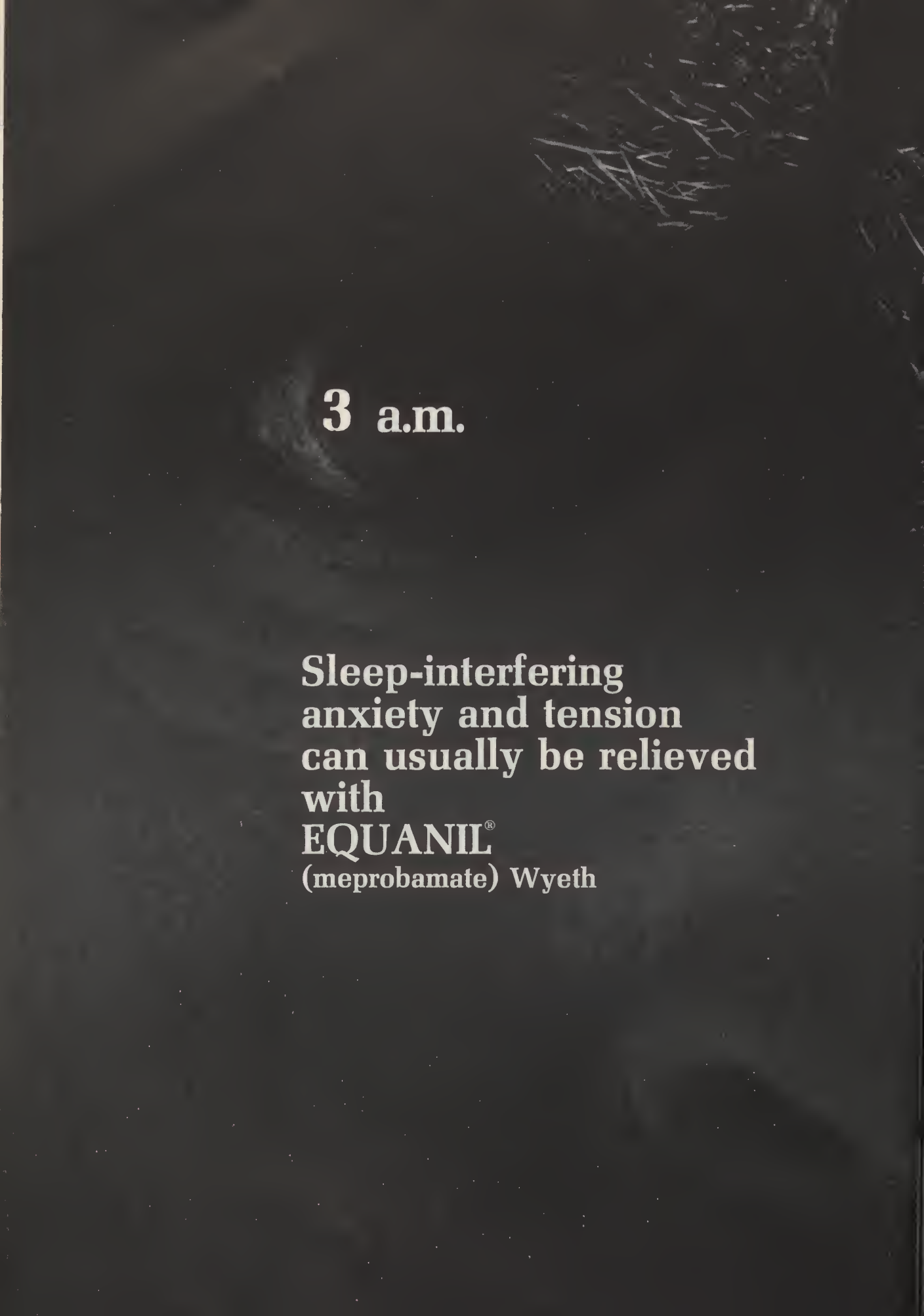


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Cautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use may result in dependence or habituation in susceptible persons—as ex-addicts, alcoholics, severe psychoneurotics. After prolonged high dosage, drug should be withdrawn gradually to avoid possibly severe withdrawal reactions including epileptiform seizures. Side effects include drowsiness and, rarely, allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute non-thrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. Meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Warn patients of possible reduced alcohol tolerance. Should drowsiness, ataxia, or visual disturbances occur, dose should be reduced. If symptoms persist, patients should not operate vehicles or dangerous machinery. A few cases of leukopenia, usually transient, have been reported following prolonged dosage. Other blood dyscrasias—aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia—have occurred rarely, almost always in the presence of known toxic agents. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. Prescribe very cautiously for patients with suicidal tendencies. Suicidal attempts should be treated with immediate gastric lavage and appropriate supportive therapy.

Contraindications: History of sensitivity to meprobamate.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

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LAKESIDE

IN BRIEF: ACTION AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion as a source of iron; infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

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ALLEGANY COUNTY

The Allegany Medical Society, recently elected L. Michael Glick, MD, as president of the Society. The remaining officers elected were: Lester Kiefer, MD, vice-president; Robert T. Miller, MD, secretary; and Albert P. Marsh, MD, treasurer.

Dr. Glick, who is practicing Internal Medicine completed his medical training at the University of Maryland and did his internship and residency at the Mercy Hospital in Chicago. In addition, he had training at Mount Sinai, and the West Side VA hospital in Chicago, Ill. He is presently a Clinical Instructor in Internal Medicine at the West Virginia State University and is a member of AMA and the American Federation for Clinical Research.



L. Michael Glick, MD

BALTIMORE CITY

Nine of the members of the board of directors of the Baltimore City Medical Society were present on April 11, 1967, at the monthly meeting held at 1211 Cathedral Street, Baltimore, Md. Harry J. Connolly MD, president of the Baltimore City Medical Society presided. Colonel Scoles, from the Kimbrough Army Hospital, Ft. George G. Meade, entered a plea to the City Society for help in placement of discharged army personnel trained in paramedical skills. He pointed out that this huge manpower pool was not being utilized efficiently upon their return to civilian life. He reminded us that these people have much to offer the civilian community and would be of great help in alleviating the shortage now existing in almost every parameter of hospital personnel. After much discussion, the board of directors decided that this important problem should be referred to the Maryland Hospital Council, the State Employment Agency, and the Specialty Sections of the State Society.

A report concerning the Baltimore City Nursing Home facilities was entered by F. F. Furstenburg, MD, who reminded us of the deplorable conditions which continue to exist in many nursing homes. He suggested, and the board agreed, that the Baltimore City Medical Society should actively pursue a program aimed at the betterment of these conditions. Further, it was suggested that the State Health Department be made aware of the City Society's position relative to this matter.

The board of directors decided that the emergency coverage questionnaire should be mailed to the members of the society with the September mail. A letter was received from the Executive Director of SAMA expressing the gratitude of the association for the society's support. Correspondence from Governor Agnew acknowledging his receipt of the society's suggested reappointment of Herman Seidel, MD, to the commission on problems of the aging, was read. Attention was

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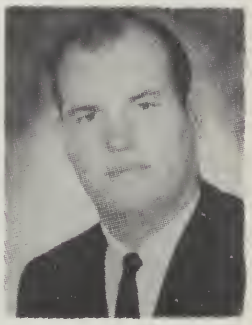
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called to the recent selection of Warfield M. Firor, MD, by the faculty committee for the Community Service Award, 1967, for his long and willing service to the community.

Arthur E. Cocco, MD
Baltimore City Medical Society
Representative to the
MARYLAND STATE MEDICAL JOURNAL

WICOMICO COUNTY

The following physicians are serving as officers to the Wicomico County Medical Society in 1967:

President: **Marcus Stephanides, MD**
Vice-president: **Robert L. Dickey, MD**
Secretary-treasurer: **Richard E. Hughes, MD**

Delegates to the Medical and Chirurgical Faculty:

Frank E. Poole, MD
H. Douglas Cooper, MD

Alternate delegates:

William C. Morgan, MD
Charles Bagley, III, MD

The Maryland Academy of General Practice

THE EVOLUTION OF A NEW SPECIALTY

The medical profession today is involved in the evolution of another specialty. The last primary specialty was formally recognized some nineteen years ago and most of the specialties were born 25 to 50 years ago. The new specialty is that of family medicine.

In viewing the steps in the evolution of any specialty, the following are evident. Occasionally the order is not necessarily the same, and many times certain steps occur almost simultaneously. These steps are (1) definition of content, (2) development of graduate (internship and residency) training programs to train skills and techniques, (3) the development of specialty departments in medical schools to train students in attitudes which will qualify them for graduate training programs, (4) the establishment of standards, (5) development of examinations to insure that these standards are met, (6) the development of continuing or postgraduate education programs to insure that the standards are maintained, and (7) the generation of research programs to develop the body of knowledge peculiar to the specialty concerned.

The "Core Content of Family Medicine" has been defined and recently adopted by the Congress of Delegates of the American Academy of General Practice as being the blueprint for the family practitioner of the future. No such similar document existed previously for the broad area of practice known as general practice. This *Core Content* will serve as a guide for the training of family physicians at all levels.

New graduate training programs are being developed and the necessary changes in present requirements governing residencies in this area are in the process of being modified to permit more flexible, improved residency-training programs.

Recommendations have been published to assist medical schools in the formation of departments of family practice. These recommendations are concisely stated in an AAGP Commission on Education publication, *The Family Practice Department in the Medical School.* Some medical schools are now embarked on the formation of departments of family practice.

The Committee on Requirements for Certification, a joint AMA-AAGP group, is engaged in establishing standards for the new specialty of family practice and early ground work on the development of examinations to insure that these standards are met has begun. Since it is planned that there will be no automatic "grandfathering" of present general practitioners into the speciality of family practice, training programs and examinations must be coordinated to assist the present general practitioners into the specialty of family general practitioners to become true specialists in family practice.

The coordination of continuing or postgraduate education courses to maintain the standards of family medicine which will be established, and to train present general practitioners in some of the newer concepts of the family practitioner of the future, is a major step ahead. One of the proposed principles applying to the new specialty is that of periodic "re-boarding" of members of the new specialty.

Stated simply, this would mean re-qualification

after a given period of time in the specialty in order to prove continued competence. To assist family physicians to maintain skills and techniques in all the areas of the new specialty as defined by the *Core Content,* a coordinated system of continuing education covering all the areas in family medicine will be developed and this, together with the experiences in practicing family medicine, will qualify the new specialist for "reboarding."

It is quite likely that the greatest contribution which the new specialty of family medicine will make to the medical world will be in the development of improved methods of the delivery of medical care. Basic and applied research in the area of the delivery of medical care will probably become the primary responsibility of this new specialty and in the course of this research the specialty of family practice will develop its own body of knowledge. Medical schools and practicing family physicians will participate in research programs.

As may be seen, the specialty of family practice is well started in its evolutionary process. Many of the steps listed above will occur at approximately the same time and progress is now being made in all of these listed steps.

However, the acceptance of the concept of such a family practice department, through which the group of practicing family practitioners can have an adequate voice in medical school affairs, may be slow. In the initial stages, the establishment of a department of family practice may be possible in but a few select institutions, and these departments will undoubtedly be observed with great interest.

The Academy of General Practice, we feel, should make no attempt in the establishment of the family practice department to specify curriculum changes other than those affecting the family practice department itself and necessary to produce the individual defineable in the core content of family medicine. The family practice department must *prove itself,* and its success must at all times be a matter of concern of the entire medical school.

With the advent of all the federal health plans it will be necessary to have a new approach for patient material for students. Patient material for teaching in the family practice or comprehensive medical department will have to be derived from the large community of patients now utilizing university hospitals as their primary source of medical care. In certain areas it may be necessary, however, for the private practitioners to relinquish some patients to the medical school in order to afford adequate teaching patients. With the increasing load upon the medical practitioners in most areas, it seems unlikely that this will cause any objections by, or financial loss to, the physicians in private practice. This teaching program in family practice is not intended to divert patients referred by their personal physician to the university medical center for specialized care.

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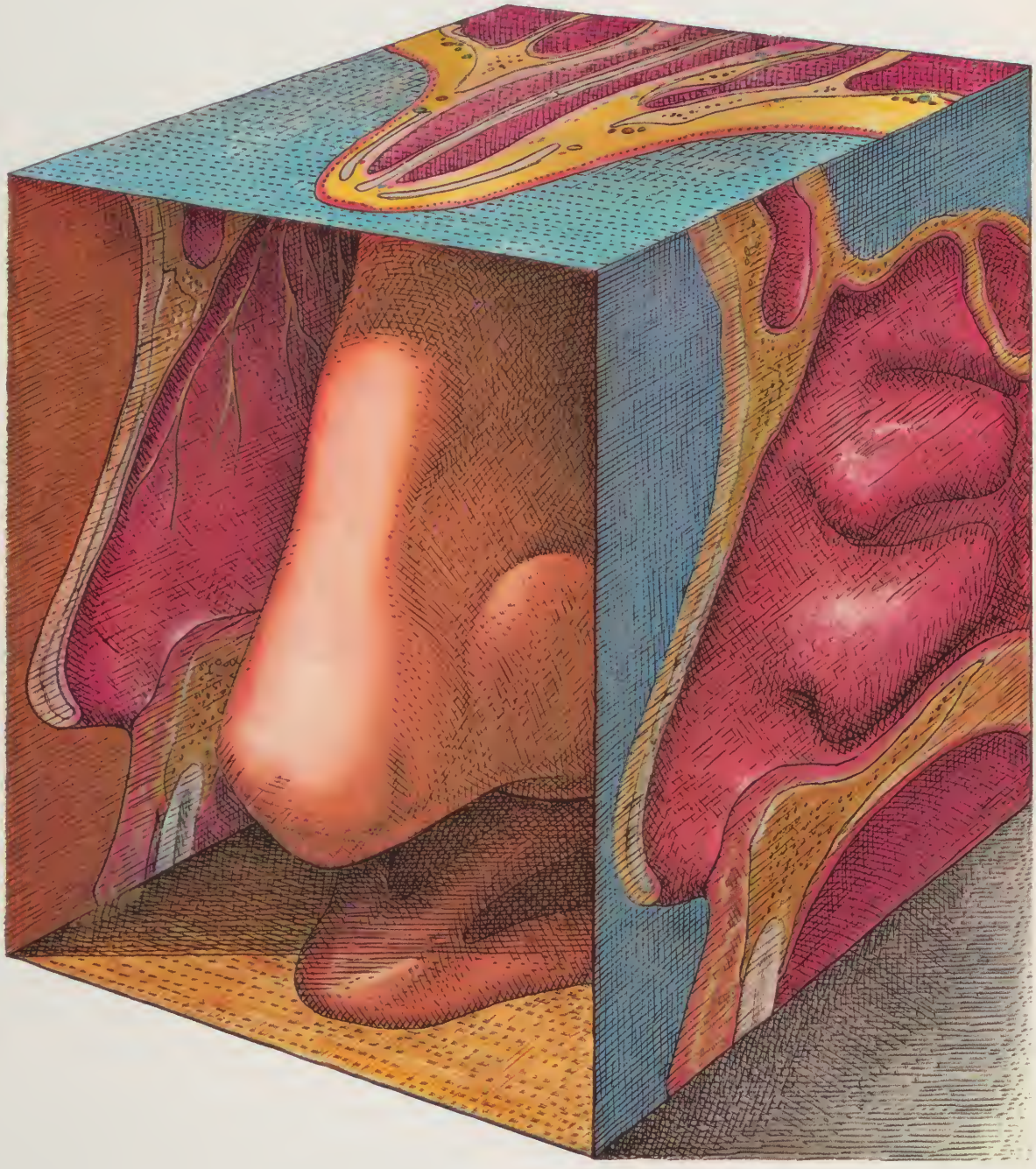
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spring 1967

DORSEY Season

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this issue: the ubiquitous world of summer allergies



the ubiquitous world of summer allergies

Donald L. Unger, M.D. • Clinical Assistant Professor, Department of Medicine (Allergy), Stritch School of Medicine (Loyola).

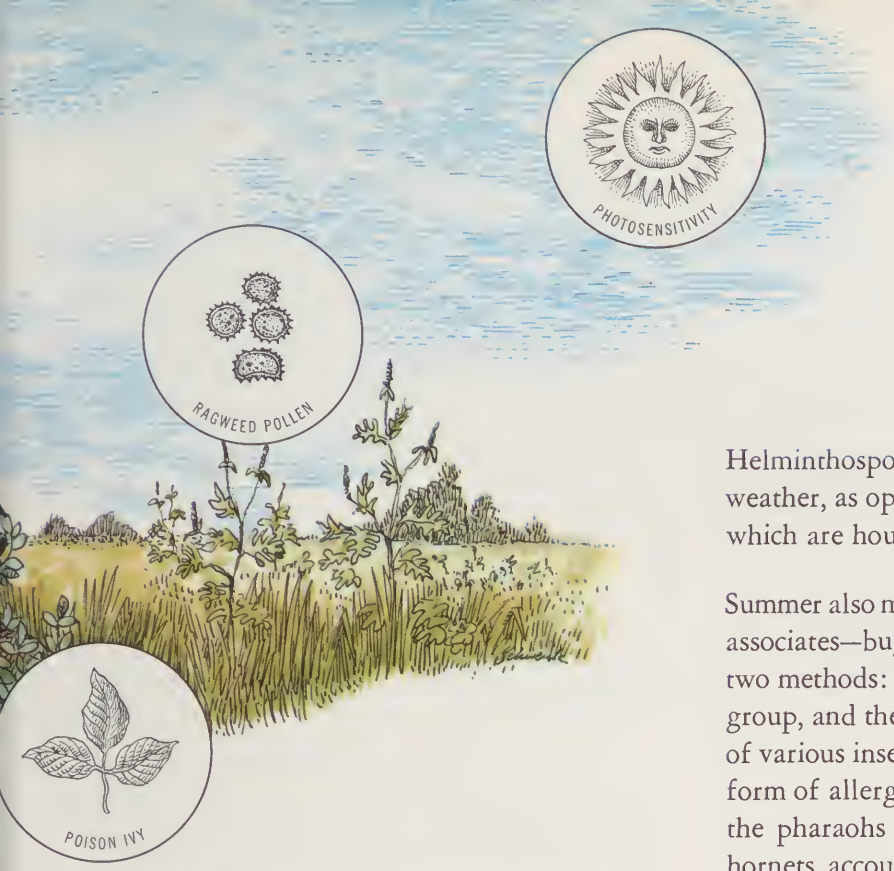
In the Spring a young man's fancy lightly turns to thoughts of—allergies. This is at least true of the 10% of the population who have hay fever and the 4% who have asthma.[1] The snow melts, the trees blossom and the noses run. Patients who were fine all winter may not be enthralled by the sight of the first robin or the blossoming of a crocus, for their appearances may precede the "sneezin' season."

Allergies in general can be divided into winter allergies and summer allergies. In the winter the main problems are inside the house: e.g. dogs, cats, dust and feathers. Houses in the northern half of the country become so dry that it becomes essential to add humidity to the home; this is a far cry from the damp summer months with the moldy basements and need for dehumidifiers.

Early in April trees begin to pollinate, with each tree having about a two week period of pollination. A particular patient may be sensitive to only one tree and thus have his hay fever for such a short time that he thinks he has a cold.[2] The entire tree season starts about April 1 and ends about Memorial Day, although all hay fever seasons are blurred and prolonged in the southern part of the country. Tree pollen is usually very heavy and a person may well have most of his exposure from those trees immediately surrounding his home.

Grasses pollinate from about May 15 until July 4, and cause "rose fever." Grass pollens are somewhat lighter and more buoyant than tree pollens, and are much more ubiquitous. While there are several varieties of grasses in the United States, they are so closely related antigenically that a person sensitive to one is generally sensitive to them all.[3] Thus, while the tree season is really several small seasons intertwined, the grass season will usually result in symptoms for a more prolonged period. Obviously, a grass-sensitive patient will have trouble only when grass is pollinating—he will have to think of another excuse not to mow the lawn after July 4.

Ragweed is the "Big Daddy" of them all in the eastern two-thirds of the country. Pollination is generally from mid-August until the end of September, with the predicted lower counts and longer seasons



in the southern part of the country. Ragweed is a very light pollen which may be windborne for hundreds of miles. An interesting study was made in New York City, in which 90% or more of the ragweed plants were destroyed in three of the five boroughs; pollen counts done during the season were virtually identical in all five.[4]

Ragweed is, of course, the most common cause of hay fever and is associated with an incredible loss of man hours from work each year. Many is the patient who travels to areas where the pollen count is low, just to avoid having symptoms. There is no ragweed anywhere in the world except the United States and portions of Canada and Mexico.

While molds are present through the year, the most important ones predominate from April until November. An old wives' tale has ragweed ending with the first frost, when actually it ends a good month earlier. It is Alternaria—the kingpin of the molds—that meets a sudden demise with the first frost. Alternaria-sensitive patients are in their glory when there is snow on the ground, and might be ideally suited to man the radar stations in Alaska. In September and October, Alternaria counts are at their highest, perhaps associated with the burning of leaves. Other molds such as Hormodendrum and Helminthosporium are associated with the warmer weather, as opposed to Penicillium and Aspergillus which are household molds.

Summer also means the return of our much maligned associates—bugs. Insects cause allergic symptoms by two methods: the bite or sting of the Hymenoptera group, and the inhalation of particles of the bodies of various insects. Wasp stings are the oldest known form of allergy, as they caused the death of one of the pharaohs in ancient Egypt.[5] Bees, wasps and hornets account for many deaths in this country, and those sensitive to them should carry special treatment kits at all times; a few minutes delay in the administration of epinephrine to such a patient, might be the difference between life and death. Inhalation of particles of insects may cause sneezing and wheezing in a susceptible individual.[6] Both of these forms of insect allergy may be benefitted by hyposensitization.

The insect recognizes no professional bounds. He is as apt to bite the physician as the patient. So this season, beware of bugs. And beware, too, of poison ivy. That pleasant stroll through the woods and underbrush with the Boy Scouts might turn into a

(Concluded on following page)

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nightmare for the botanically uninitiated in the causes of rhus dermatitis (poison ivy, poison oak and poison sumac). Although you may have been careful, your dog may not have noted that it wasn't clover he jumped through, but poison ivy. His return to your side may give you the rhus dermatitis that you so carefully avoided. That heavenly campfire may be emitting particles of rhus oil to produce an airborne contact dermatitis of the exposed areas of the body.

Another fascinating, but rather infrequent type of summer allergy is physical allergy. Some people sneeze on exposure to sunlight, while others break out in rashes, usually on the exposed parts of the body. These rashes may well follow the administration of various photosensitizing drugs, e.g. demethylchlortetracycline.[7] Another form of physical allergy and one that may be lethal in the summer, is cold allergy. Yes, I mean cold allergy, not heat allergy. The cool dip on a hot day with its consequent sudden chilling of the body, may be the coup de grace for a cold sensitive patient.[8] It is customary to write "heart attack" on the death certificate, even though the victim may have been an 18-year-old boy who looks like a Greek god.

Lest the reader be depressed by this saga of afflictions associated with the warmer months, perhaps he should remember that it is also a time for swimming, baseball, lying in the sun and taking that long-planned vacation. So let's all join in a chorus of "In the Good Old Summertime," as we sneeze, wheeze and scratch. Be careful of your suntan lotion, however; it may cause you a contact dermatitis.

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How can he be a sport with a runny nose?



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the HEART PAGE

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Elijah Saunders, MD—*Editor*

Transient Ischemic Attacks of the Brain: Part 1—Diagnosis

ERLAND NELSON, MD, PHD
Professor and Head, Department of Neurology
University of Maryland School of Medicine

Transient ischemic attacks (TIAs) of the brain are, paradoxically, not only the most misdiagnosed and neglected of the varieties of cerebrovascular disease, but are also the most amenable to therapy. While there may be frequent recurrent attacks which never progress to a completed stroke, it is clear that in many instances, the TIA presages a cerebrovascular catastrophe. The term *transient ischemic attack* is appropriate, for the symptoms are not long-lasting but are usually present from only a few minutes up to an hour; they are due to cerebral ischemia and are to be distinguished from the hemorrhagic types of cerebrovascular disease; and they are "attacks," swift in onset, and do not produce a gradually developing deficit.

The diagnosis of TIAs is made almost exclusively by history. While an evanescent toe sign or nystagmus at the time of the examination may further corroborate the significance of the patient's history, the majority of the patients with TIAs have a normal neurological examination. This fact has, no doubt, led both patient and physician to dismiss the symptoms of transient cerebral ischemia as being either psychogenic or of no consequence. Because of present rational therapeutic measures, such attitudes are no longer appropriate.

Fundamental to the diagnosis of transient cerebral ischemia is an awareness of certain anatomical features of the vascular and neurological systems. Thus, there is a therapeutically significant separation of the blood supply of the brain into *extracranial* and *intracranial* circulation. The intracranial cerebral vessels are further divided functionally into an *anterior* circulation derived from the internal carotid arteries and a posterior circulation flowing up from the vertebral-basilar system. Further, there is the possibility for collateral blood flow at the circle of Willis or over the brain surface as well as from external to internal carotid territory by several routes. The symptoms of which the patient complains are, in the last analysis, the result of ischemia in a certain portion of the *brain*. The condition of the supplying vessels, and the degree of collateral flow available are important variables that may determine not only whether symtoms will occur, but if the transient symptoms will become permanent deficits. Two symptoms, monocular visual loss and aphasia are pathognomic of anterior circulation insufficiency. Characteristic of posterior insufficiency are vertigo, incoordination, diplopia, dysarthria or "drop attacks." Insufficiency of either anterior or posterior systems may produce unilateral sensory or motor deficits, or homony-

mous field cuts. A shifting hemiparesis, hemihypesthesia, or hemianopsia favors insufficiency in the vertebral-basilar system. This distinction has prognostic and therapeutic importance.

Certain features in the general physical examination may provide clues giving further weight to a history compatible with TIAs, eg, production of symptoms with head turning; neck or supraclavicular murmurs; auricular fibrillation; or a 20-point systolic variation in pressure and pulse lag in the two arms, indicating a "subclavian steal syndrome." In other instances appropriate laboratory studies reveal the presence of either polycythemia or anemia, myocardial infarction or cervical spondylosis. Consideration must be given to those conditions which may mimic TIAs and further questioning and appropriate tests may need to be done to rule out epilepsy, migraine, Meniere's syndrome and conversion reactions. In the next issue of *The Journal*, THE HEART PAGE will be devoted to a discussion of management of patients with transient ischemic attacks.

A Stroke Program Office has been established under the aegis of the Maryland Heart Association for a pilot study to register Stroke Cases in the community. This Registry will provide invaluable information on the several varieties of cerebrovascular disease, including natural history, results of therapy and influence of a number of environmental and hereditary factors. The full cooperation of Maryland physicians is earnestly requested. Further information concerning this program will be mailed directly to physicians by the Maryland Heart Association.—ED.

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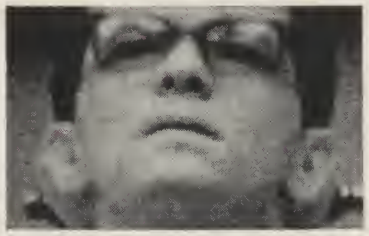
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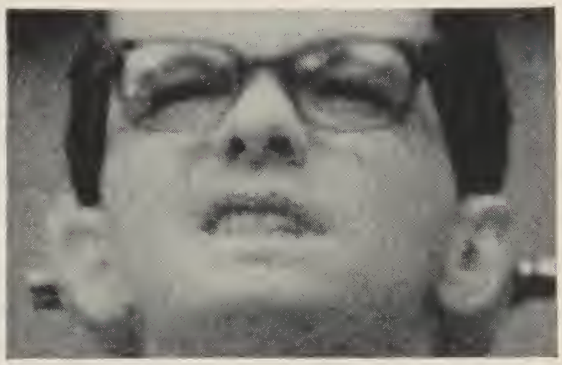
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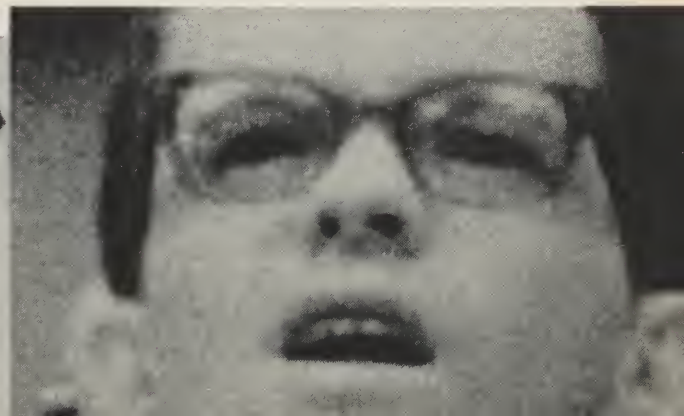


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Alcoholism SECTION

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

Pennsylvania Department of Health Notes Dangers of Conjunctive Use of Alcohol and Drugs

The public shock waves of sudden death from the conjunctive use of alcohol and drugs should have long since cast an unfamiliar phenomenon into a household truth.

That phenomenon is "potentiation," and the remoteness of its meaning from the public mind is still lethal.

Dictionaries define *potentiation* as "the combined action of two drugs being greater than the sum of the effects of each one alone."

Twenty years ago, experiments at the Medical College of Virginia indicated "a synergism between the barbiturates and alcohol." Mortality rates in those experiments jumped an average 60% when sublethal doses of alcohol were given in combination with barbiturates.

Potentiation is what another team of research scientists meant two years later when they concluded a report on their observations in the *American Journal of Clinical Pathology* with the statement:

"Examples are presented in which death was apparently due to the combined effects of alcohol and barbiturates, each of which was present in concentrations not ordinarily considered fatal.

"The danger incident to the indiscriminate use of the two agents at the same time is stressed."

The Virginia researchers also ventured, even then:

"The widespread use of both alcohol and the barbiturates would appear to make important a more thorough knowledge of the effects that may ensue when they are administered jointly."

But those admonitions have been all but lost on contemporary generations.

Today, the need to expound the meaning of potentiation into the common knowledge of a frenetic society is hardly less critical. The recent deaths of prominent personages caused by the alcohol-drug potentiation only beg a flood of the larger questions.

What is the incidence of death from the alcohol-drug problem among Americans generally, including those of lesser importance to the news media?

How many death certificates list the conjunctive ingestion of alcohol and drugs as the primary cause of death?

What are the portents of the incidence of combined use?

Barbiturates are frequently mentioned, but what other drugs are used in combination with alcohol?

What drives people to the conjunctive use of alcohol and drugs? How do they become "trapped by the double addiction"?

To say that the answers to those questions are not readily available would be to understate the case. Pat answers are non-existent. Facts are rare. Data are scattered and spotty. Observations are

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guarded and meagre.

But thanks to a few lonely explorers in this "new and significant field about which we know so little," there are clues and they form the vague outlines of patterns—however nebulous and disjointed they may at first seem:

Dr. Joseph W. Spelman, chief medical examiner of Philadelphia's Department of Health, reports that preliminary studies of "coroner's deaths" in the city last year (1965) compare with the findings of the unique study made in 1961 when the combined use of alcohol and drugs was found to be the direct cause or major contributing factor in 209 cases of suspicious, unattended deaths.

Dr. Spelman himself emphasizes, however, that the 1961 study was stringently limited; that first, only those deaths "of a type coming under the purview of the coroner" were encompassed by the survey, and that secondly, less than half of those (only cases of instantaneous death) were subjected to specific tests. At best, the 209 cases cited could tell only a small part of the epidemiologic story.

Dr. John A. Dattoli, director of the State Department of Health's Division of Behavioral Problems and Drug Control, also points to the epidemiological limitations. The major difficulties, says Dr. Dattoli, are to be found in the official records, the death certificates.

The inadvertent, justified or intentional omissions of such a concomitant cause of death as the deceased's use of alcohol and drugs have been known to occur. The physician may think in such frames of reference as "primary," "principal" or "secondary" causes of death. The habits of the deceased may be of little concern to him, if, in fact, he has known the deceased well enough to have any more than a suspicion of addiction.

On the other hand, and this point Dr. Dattoli stressed, after listing the known and contributing factors of death the physician may find there is just no space on the certificate for an indication of alcohol and drug abuse.

Fifty Per Cent of Patients Suffering Double Addiction

Dr. Charles Gabos, director of the Department of Alcoholism, St. John's Hospital, Pittsburgh, reports that, on the average, he attends 30 alcoholic patients a month. He freely estimates that 50% of these patients are suffering, or have suffered, the double addiction of alcohol and drugs in combination.

Dr. Gabos offers an arresting epidemiologic sidelight: "In my experience, it seems that the incidence of the combined use of alcohol and drugs is greater among women than among men."

In those observations, Dr. Gabos enjoys the concurrence of Dr. William W. Unangst, director of Norristown State Hospital's alcoholism program and its Center for Alcoholic Study and Therapy (CAST). Says Dr. Unangst:

"Half of our alcoholic patients have been involved also with drugs. Alcoholism frequently is the first step in drug addiction. Many people graduate to the realization that while there remains a stigma with the intemperate use of alcohol, there is no such stigma attached to the use of the recently developed tranquilizers and hypnotic drugs.

"Actually, in some areas the use of such medication has become a status symbol, and housewives openly compare the relative merits of Miltown, Librium, Valium et al."

The specific incidence of combined use among women, or men, or the affluent or the economically depressed, or any other category of the population is, of course, unknown.

The White House Conference Report on Narcotic and Drug Abuse makes a relevant confession: "Adequate data are not available for a precise estimation of the incidence and prevalence of the abuse of drugs with psychotoxic side effects."

Despite that blanket negation and also the fact that the Report is dealing primarily with drugs other than alcohol, the White House panelists offer "some important epidemiologic clues" that again have some relevance to a study of the alcohol-drug potentiation:

"There are large numbers of drug abusers who never come to the attention of community agencies."

"There is an increasing abuse of nonnarcotic drugs concomitant with a decrease in the abuse of narcotic derivaties."

"The frequently cited change from a prewar population of white users with a female majority to one drawn primarily from minority ethnic groups with male preponderance appears to be correct for some geographical areas but incorrect for others where the white still constitute the

majority of abusers."

"There is a possibility that the abuse of barbiturates and amphetamines among juveniles may be increasing because they are so much cheaper, more readily obtainable, and easier to handle."

200,000 New Alcoholics a Year, Authority Estimates

To those clues add the shocker that Dr. Robert Greenhouse dropped at the Pennsylvania Conference on Alcoholism this year:

"Alcoholics in the U.S. are increasing at the rate of 200,000 a year and most of these new alcoholics are young people."

The suggestion of a "potentiation of clues" is inescapable.

How many alcoholics—or just "social drinkers"—of the new persuasions of nihilistic sophistication find it cool and convenient to avoid sweating out an alcohol withdrawal syndrome—or even a hangover—by the conjunctive use of drugs?

How many use barbiturates or any of the new synthetic sedatives as an alternative to alcohol on those occasions when alcohol—because of its odor, ataxic effects, transport or other incriminating attributes—is less convenient?

How many—to retain the euphoria, hide the symptoms, relieve the malaise, dispel the depression of alcoholism when trapped in the intermittent dilemmas of alcohol saturation and withdrawal—simply go for a pill, the right pill at the right time or, if worse comes to worse, any pill, any time? The White House Report again clues the new compulsion:

"The two agents (alcohol and barbiturates) are mutually interchangeable in creating or perpetuating the dependent state. In fact, many alcoholics turn to barbiturates in an attempt to conceal their problem, and avoid the social pressures which stigmatize the alcoholic. . . ."

The Report suggests also that the use of amphetamines to counteract or "to antagonize the depressant effects of alcohol and barbiturates" is a "common type of abuse."

Ten Million Americans Seen Impairing Capacity to Live

Again, Dr. Unangst is less inclined to understate the problem. Citing more recent surveys for support, CAST's director claims:

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10 million people in this country who are impairing their capacities to live fully and function effectively by the use of alcohol and drugs.

"Although cancer and heart disease are still considered the major public health problems in America, I am inclined to hold that when all the destructive factors—economic, social, cultural and emotional—are considered, alcohol and drug addiction is the greatest threat to our society.

"When a man dies of a heart attack or cancer his children are not ashamed to go to school, or his wife to church; but when a man dies of DT's in the gutter or a mother destroys herself by overdoses or potentiation of alcohol and drugs, the scars remain for a full generation."

An empathic, if psychological, approach to the problem of addiction is offered by Dr. James H. Ewing, of Philadelphia's Mercy-Douglass Hospital, who contends, in effect, that man's freedom to dream is as important to his mental health as his freedom to sleep is to his physical health. Constantly recurring interruptions of the dream inceptions and sequences—as have actually been effected in experiments—lead to critical emotional disturbances.

But man has concomitant needs to reflect and to meditate in his waking hours as well as to dream in his sleep. The pressures and tensions of today's society are not always conducive to the inception or integrity of inspirational thought and there results a sustained inner conflict between the daily requirements of work and the need for meditative freedom.

The integration of these two processes is vital to man's peace of mind, if not to his best work. And he finds, inadvertently or otherwise, that the inspirations of syncretic thought can be conjured up like magic through the use of alcohol and drugs. Especially is this said to be true of those upon whose insights, depth of feeling, gifts or talents there is any demand whatever.

The thesis extends naturally to the college generation. "College makes tremendous demands on the student for the organized accumulation of great sums of knowledge," Dr. Ewing points out. "At the same time it stimulates a welling up of emotions along with new interests in the world and new needs for expressive thought. The student is trapped between the requirements for cultural information and the impulsions of creative, inspirational experience. He's in intense conflict; and the resolution of the conflict is in the integration of the two kinds of thinking demanded. Such integration, or syncretic thought, says Dr. Ewing, "isn't adequately encouraged."

So the college student, "just like any creative person who is frustrated by conflict," turns to alcohol and drugs for the "liberation of his inspirations of syncretic thought, the continued exercise of which seems to be essential to his mental health."

But Dr. Ewing hastily points to the limitations:

"The trouble with the use of alcohol and drugs is that while ideas and emotions may be temporarily freed, the complex mental operations which have to do with constructive elaboration, redefinition, and refinement of an idea cannot be brought to share in the creative task. So while the use of alcohol and drugs liberates certain creative functions, it usually fails to facilitate the full complicated and highly-patterned sequence of mental operations essential to the creative act."

Tranquilizers Used With Alcohol Are Deadly Also

While barbiturates and amphetamines seem to draw primary blame for complicity in the alcohol-

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drug potentiation, most any drug is vulnerable to indictment. And especially does this seem to be true of the tranquilizers.

Pharmacologists Robert B. Forney and Francis W. Hughes, of the University of Indiana's School of Medicine, in a preface to their research report on the synergistic action of tranquilizers and alcohol, state that:

The increased use of tranquilizers and the "continued, socially acceptable widespread use" of alcohol indicate that "this combination must occur frequently."

The growing suspicion that tranquilizers in combination with alcohol can be as deadly as any other drug gains credence with Dr. Spelman's continuing studies in Philadelphia. In the 1961 survey of suspicious, unattended deaths, the barbiturates were found to be the drug most frequently used in combination with alcohol. Now, Dr. Spelman reveals, tranquilizers, with alcohol, are pushing barbiturates for the infamy of top killer.

In combination with alcohol, not even a "safe" drug is safe. Under most conditions, paraldehyde has been considered a "safe" drug; in fact, it has been known as one of the safest of the hypnotics. Ironically, over the past 80 years, it has frequently been known as the "drug of choice" for treating the symptoms of acute alcoholism.

But last year, researchers Sidney Kaye and the late Harvey B. Haig reported on their study of nine individuals who died suddenly and unexpectedly following paraldehyde therapy for acute alcohol intoxication. All patients were ambulatory, "abusive" and apparently in good health except for the symptoms of alcoholism. Deaths occurred a half hour to four hours after administration of paraldehyde, and autopsies revealed no morphologic causes of death in any case.

The irony of the alcohol-drug potentiation is stated by Dr. C. Nelson Davis, psychiatrist-in-chief, Malvern Institute for Alcoholic and Psychiatric Studies:

"Man's proclivity to abuse a drug, rather than use it properly when administered for its best pharmacological purposes, has the power to completely submerge the drug's usefulness:

"And so the paradox. The drugs that are used in the alcoholic's acute phase become the very instruments of a more serious complication of his disease. The alcoholic patient has in some cases

become dependent on every drug used to alleviate his suffering."

At this point, a provocative observation of Dr. Unangst extends the prognoses of addiction and potentiation to the overall area of emotional illness. Dr. Unangst contends:

"The separation of addiction from the overall, total problem of emotional illness attempts to establish a dangerous and arbitrary dichotomy. Alcoholism is the cancer of emotional illness. And each of the four categories of mental illness—the neuroses, psychoses, character disorders and psychosomatic disturbances—may predispose to, be compounded by, and ultimately be buried beneath the far greater destructive forces of alcohol and drug addiction.

"While one-seventh of all first admissions to public health hospitals in 1960 were alcoholics, a careful scrutiny of pre-admission histories in two separate Pennsylvania hospitals revealed that one-half of all admissions involved the excessive use of alcohol or drugs, or both, during the period of emotional decompensation.

"It must be concluded that the use of alcohol and the injudicious use of any drug represents a realistic threat to those suffering from any form of emotional disorder.

"While the addiction may be technically symptomatic, it ultimately is the primary instrument of the patient's deterioration and destruction."

As though the portents and enigmas of the alcohol-drug potentiation were not challenge enough, the newest problem posed by the Conjurer of Compulsions epitomizes all contemporary addictive sophistications. It's the "spree use" of drugs, a behavioral orgy in which the abuser flits from one drug to another, uncannily avoiding dependence on, or tolerance to any single drug. He may run the whole gamut: alcohol to barbiturates to amphetamine to opiate to cocaine and back to alcohol. And he gains the added advantage of being just as sensitive to each new dose as to the original one.

There is here the subtle suggestion of habituation rather than addiction, and the equally subtle implication of safety. Not so, say the White House panelists. "Spree use" appears to be no less hazardous and may engender the same types of antisocial behavior.

There is, lastly, a further implication: that far more people survive the combined use of alcohol and drugs than succumb to it. Is sudden death the exception? What about the apparently great numbers who from day to day go on and on with their double addiction? Dr. Forney provides the one and only pat answer:

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In the portentous public health area of alcohol and drug abuse, conquest is not likely to temper the zest to explore any more than solutions will void the challenge to empathy—for some time to come.

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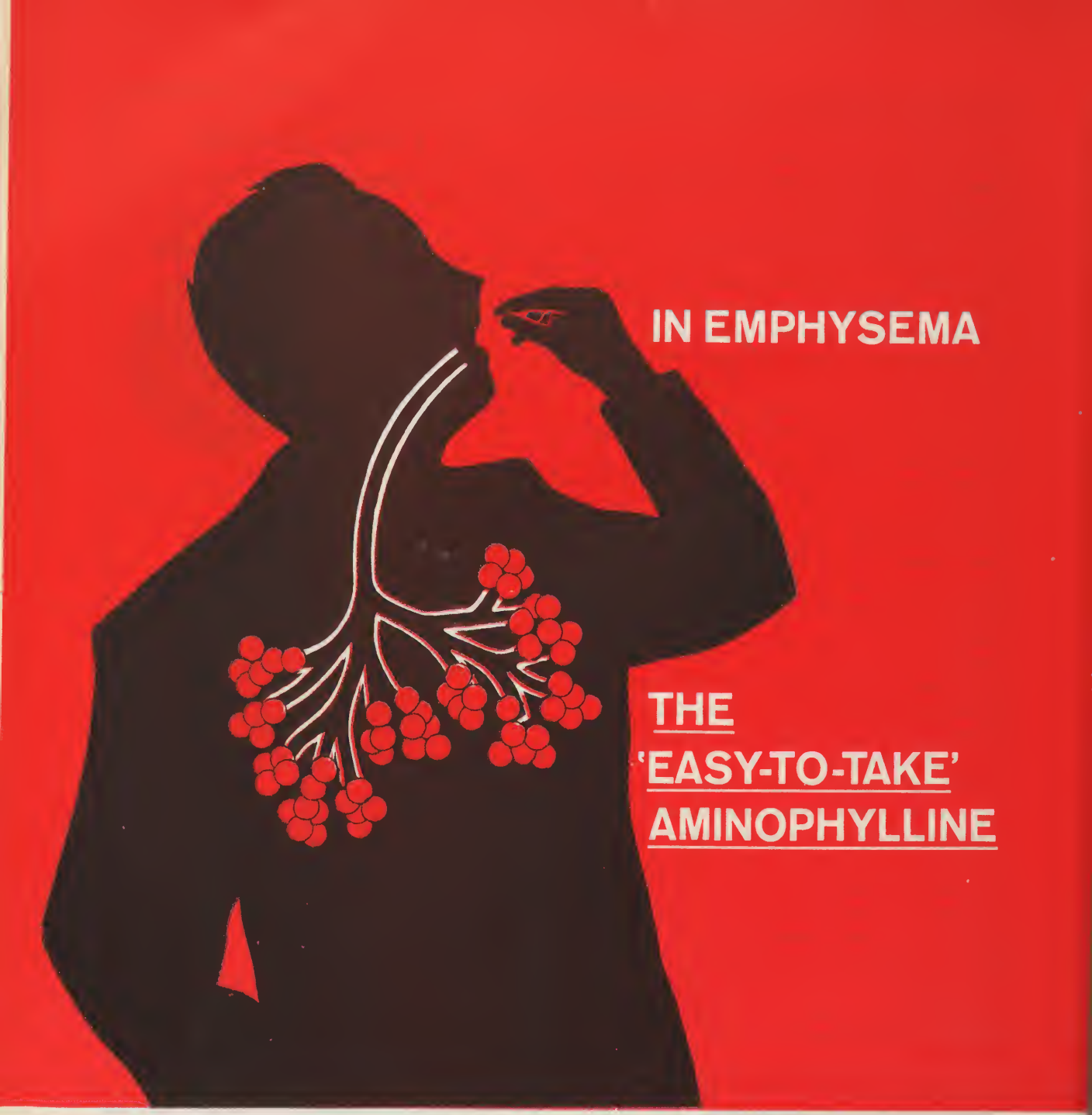
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Department of Mental Hygiene

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Accidents

A total of 174 deaths due to accidents was reported to the Maryland Psychiatric Case Register in the three years from July 1, 1961 to June 30, 1964, among the 66,006 patients under treatment in a reporting inpatient or community facility at some time during this period. Of these, 103 occurred while the individual was hospitalized and 71 after he was released or while he was under outpatient care. Falls, the leading cause of these deaths, occurred primarily among senile, hospitalized patients. The following table shows the distribution of the deaths by type of accident and by the patient's reported diagnosis. As indicated, these represented only a small proportion of total deaths from these causes among Maryland residents.

Reported Patient Diagnosis	Total	Cause of Death: Motor Vehicle	Poisoning	Falls	Drowning	Suffocation	All Others
Brain Syndromes*	76	4	3	49	1	9	10
Psychotic Disorders	29	4	1	11	2	7	4
Alcoholism	33	5	6	11	3	—	8
Psychoneurotic and Personality Disturbance*	25	12	2	4	2	—	5
All Others	11	2	—	4	1	4	—
Total	174	27	12	79	9	20	27
Percent of all Maryland Deaths from This Cause	4.0%	1.6%	5.4%	8.3%	3.8%	24.%†	2.4%

* Except Alcoholism
† 100% = 80

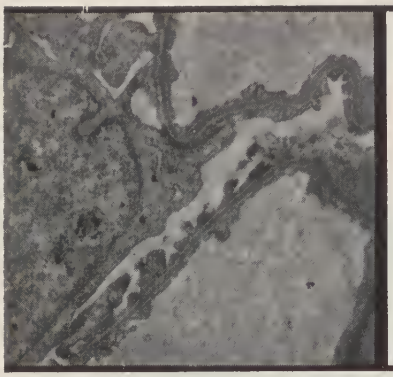
It should be recognized that these data do not reflect the total number of accidental deaths among individuals who have ever received psychiatric care since they exclude those who had completed treatment prior to July 1, 1961. However, this number is believed to be relatively small.

A previous newsletter reported that suicides were proportionally more frequent among current or former patients than in the general population. While the accidental death rate appears similarly to be somewhat higher, both of these causes accounted for only a small part of all the 4,385 deaths reported to the Register (136 and 174, respectively). In addition, ten deaths due to homicide were reported to the Register.

These data indicate that deaths from violent causes are a relatively minor factor in the high mortality rates reported among individuals who have been under psychiatric treatment. Further, the small number of deaths from motor vehicle accidents, poisoning and falls from one level to another would appear to run counter to the concept that many accidental deaths are disguised suicides.

A recent study‡ by the Register staff of patterns of retention, release and rehospitalization among specified groups of patients admitted to Maryland's three major psychiatric hospitals indicated high mortality rates, particularly among alcoholics. Further detailed analysis is now in preparation.

‡ Release And Return Rates For Patients In State Mental Hospitals Of Maryland, *Public Health Reports* **81**:1095-1108 (Dec) 1966.



MARYLAND SOCIETY OF PATHOLOGISTS INC.

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Doctor, Look at Your Malpractice Insurance!

WALTER BRADLEY KING, JR., MD

All physicians should be aware that malpractice, a subdivision of the broader subject of negligence, is a term addressed to the situation wherein a patient is injured as a result of careless or negligent treatment by a physician or as a result of treatment not up to the accepted standard of medical practice. Thus, a malpractice judgment may be found against a physician when the physician was inadequately skilled or trained to carry out a particular procedure, was careless, or was not using his best judgment.* Error by itself is not grounds for malpractice, assuming that the best judgment of the physician was used. The subject of this brief dissertation, however, is not what constitutes malpractice; rather, it is what does *not* constitute malpractice in the ordinary daily practice of medicine, but is nevertheless a possible source of physician liability.

One approach to discuss what is *not* malpractice, for all practical purposes, is to indicate what insurance companies may *not* cover under their "malpractice" insurance clauses or policies. Specifically, a "malpractice policy" *may not* cover the physician in the ordinary practice of his profession for *personal* liability, ie, damages resulting from personal injury or property damage; similarly, it may not cover *professional* liability *outside* of the physician's literally professional services.

This means, then, that when a physician is not acting as a physician per se, ie, healing the sick, he may not be covered by malpractice insurance against certain lawsuits. Examples might involve injury arising during, but not from acts of diagnosis or treatment what may be considered slander or libel; or an otherwise inconsequential action or comment, or simply the vulnerability of the physician. Clearly, it is difficult to practice medicine today without participating in professional organizations or on hospital committees. It is possible, however, if a physician is candid in ihs approach to such responsibility that anything he says or writes may be misconstrued.

*Cusumano, C.L.;, Malpractice Law Dissected

*Cusumano, C. L.; Malpractice Law Dissected for Quick Grasping, New York: Medicine-Law Press, Inc., 1962.

As a result, he may find himself the uncomfortable recipient of a lawsuit without any protection or, equally as bad, without enough coverage under his "malpractice insurance," and with only legal counsel.

For the physician in private practice, the desirability of having his malpractice insurance with the same company that carries his liability insurance is also a point to consider; then, in the borderline case, there will not be a squabble between two insurance companies as to which should defend the case and/or pay the claim.

This discussion is not meant to be an advertise-

ment for any particular type of insurance or insurance policy—it is only meant to make physicians think about the professional insurance protection for which they are paying and to open their eyes for what they are and are not insured, in contrast to what they *think* their coverage is.

Several examples come readily to mind:

1. Allegation of libel and/or slander against a staff physician who honestly believes that another physician who is applying for hospital privileges is not up to the standards of his hospital and says so. The staff physician is not practicing medicine at that time (in the literal sense, that is, though he is certainly practicing it in the ethical and moral sense) and so *may not* be covered by his "mal practice" insurance policy. Should he be sued, he may find it expensive to fight and *win* the suit, even more so to fight and *lose* the suit.

2. Allegation of "undue familiarity" against the physician by a female patient.

3. Allegation of humiliation in a situation where a physician makes what was intended to be a teasing remark about a patient that is misinterpreted. For example, the physician says jestingly to a patient, in the presence of some visitors, "How is my most difficult patient today?" Jesting, yes, but dangerous!

4. Allegation of personal liability against a cardiologist when a patient doing a Master's Test slips on the waxed floor of his office and breaks his leg.

A list of examples could be almost endless; its only purpose would be to encourage physicians to consider their professional insurance coverage, recognize some of the inadequacies in many existing policies and, thus, prevent their being caught uncovered or inadequately covered, which *could* be both expensive and time-consuming.

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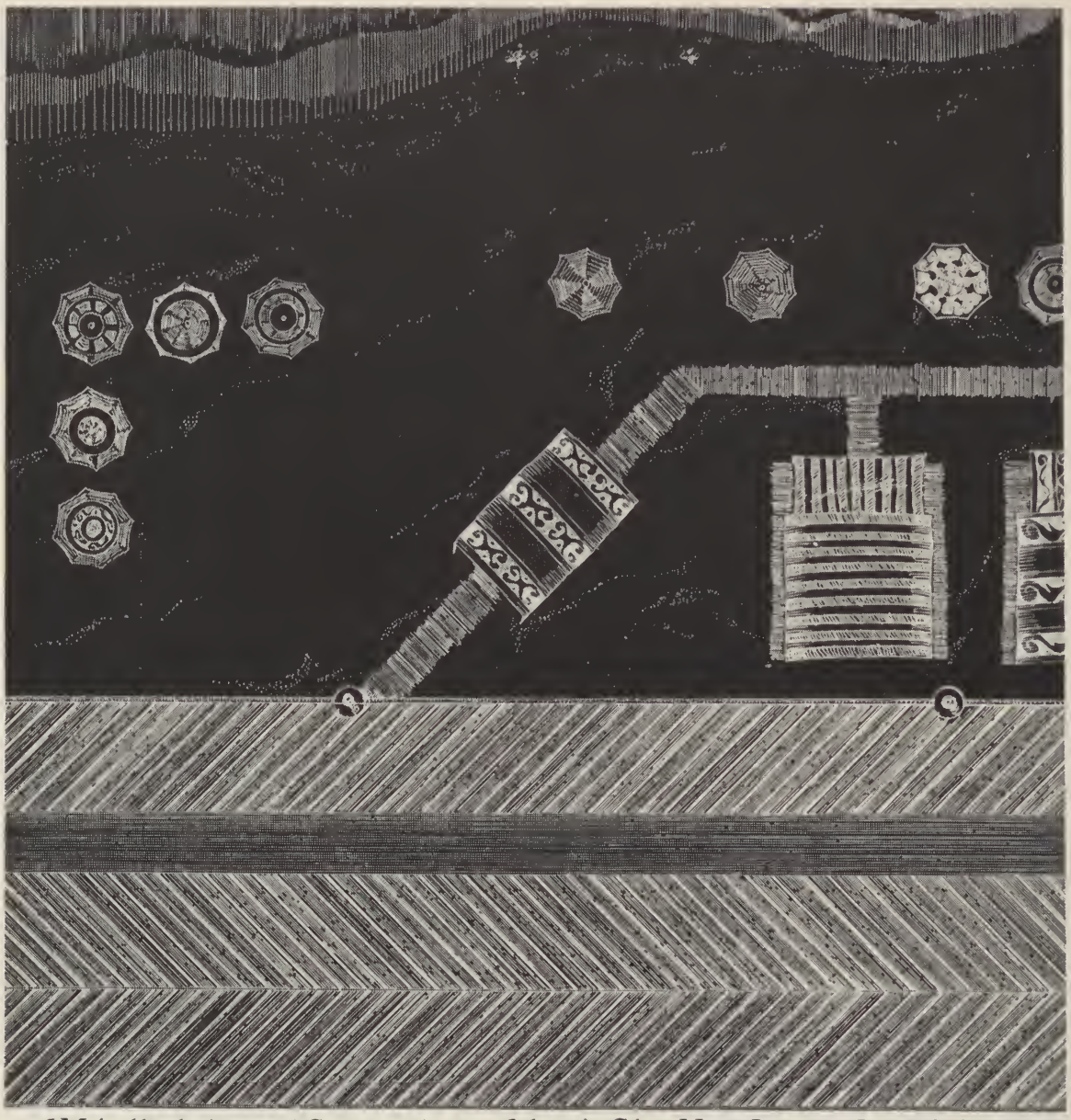
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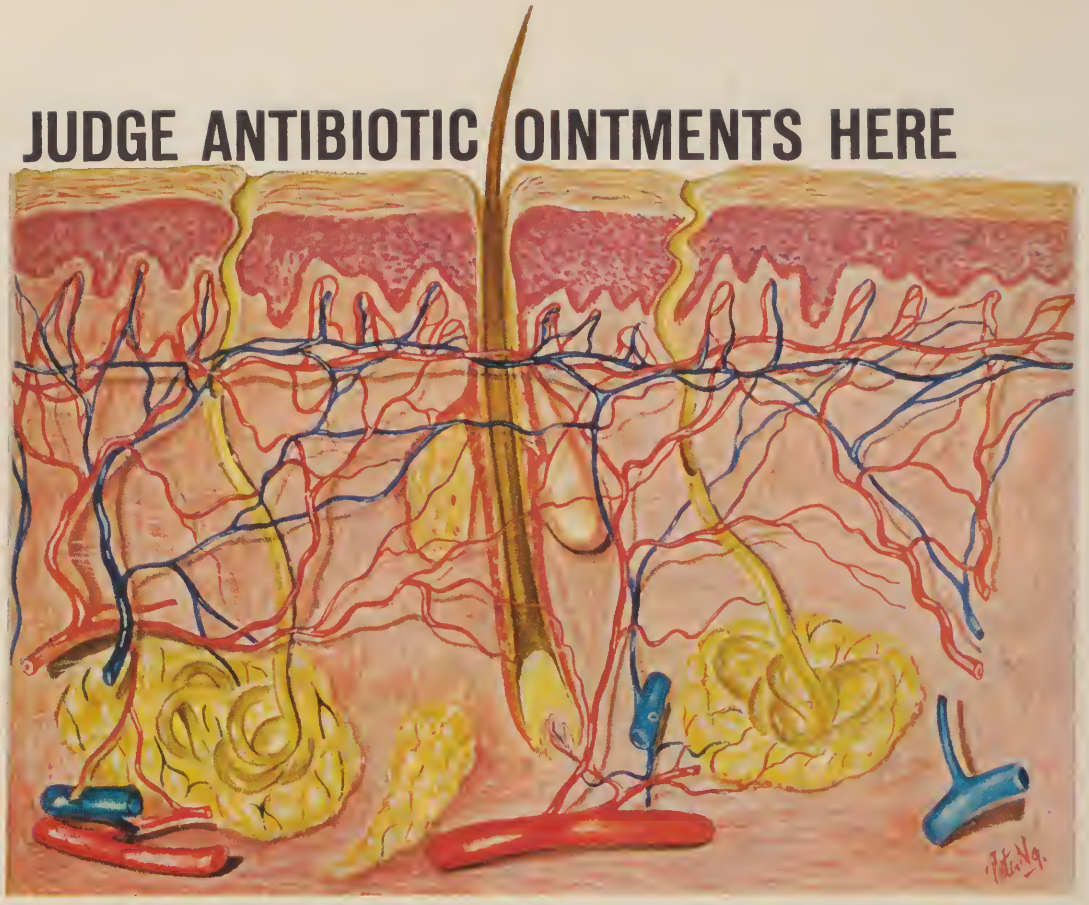
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DOUGLAS G. CARROLL M.D.
EDITOR

THE HAND IN RHEUMATOID ARTHRITIS: Part 1

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Laine reports that 288 of 305 patients with rheumatoid arthritis had deformities of their hands.[1] The most common deformity was the "buttonhole" (boutonniere), followed by ulnar deviation, tendon nodules in the flexor tendons, "swan-neck" deformity, trigger-finger, tendon nodules in the extensor tendons, baseball-finger (non-traumatic), contracture of collateral ligaments and spontaneous rupture of the extensor pollicis longus.

Inglis recognized four disabling deformities of the rheumatoid hand: thumb deformities, swan-neck (intrinsic plus) in digits 2 to 5, the buttonhole deformity of digits 2 to 5, and ulnar drift.[2] The thumb was involved in 50% of the patients with structural changes in the hand.

Pathogenesis

Three major processes conspire to deform and limit hand function in rheumatoid arthritis: pain, destruction and attenuation of the tendons, and erosion and dislocation of the joints. All of these processes seem to follow proliferation of synovial tissue. The invasion of the joint by synovial tissue is accompanied by pain, swelling, joint fluid and an inflammatory reaction. In the wrist, tendons are often involved in the neoplasm-like growth of synovium. Neither the cause of the synovial proliferation nor the exact mechanism of joint and tendon destruction is clearly understood.

The mechanisms of the development of hand deformities are multiple and differ from patient to patient. On the following pages, three hand deformities are described, illustrated and explained,[3-7] and their physical and/or surgical treatment presented.[8-11]

From the Hand Clinic, and Department of Physical Medicine Baltimore City Hospitals.

Buttonhole Deformity:

Figure 1 shows a digit with a typical buttonhole deformity. The proximal interphalangeal (PIP) joint protrudes posteriorly through the attenuated or destroyed central slip of the lateral interosseous bands of the extensor mechanism. Figure 2 shows one way in which the central slip may be repaired surgically to prevent herniation of the PIP joint.

Swan-neck Deformity:

Figures 3 and 4 illustrate the swan-neck deformity. A number of factors conspire to cause it. If the proximal phalanges are displaced in a volar direction, the intrinsic muscle-pull shifts dorsally. Thus the pull of the intrinsic muscles causes hyper-extension of the PIP joints of digits 2 to 5. The tendon of the flexor digitorum profundus pulls the distal joint into flexion. At later stages the PIP joint may ankylose in extension. Figure 5 shows one type of surgical correction of this abnormality.

Buttonhole and swan-neck deformities are com-

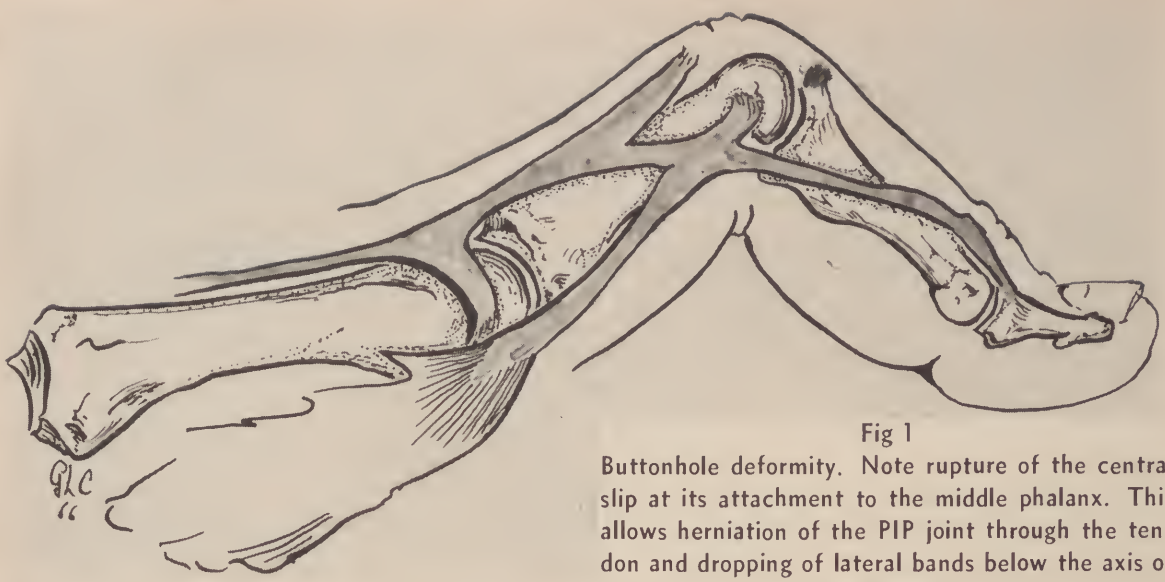


Fig 1
Buttonhole deformity. Note rupture of the central slip at its attachment to the middle phalanx. This allows herniation of the PIP joint through the tendon and dropping of lateral bands below the axis of the joint.

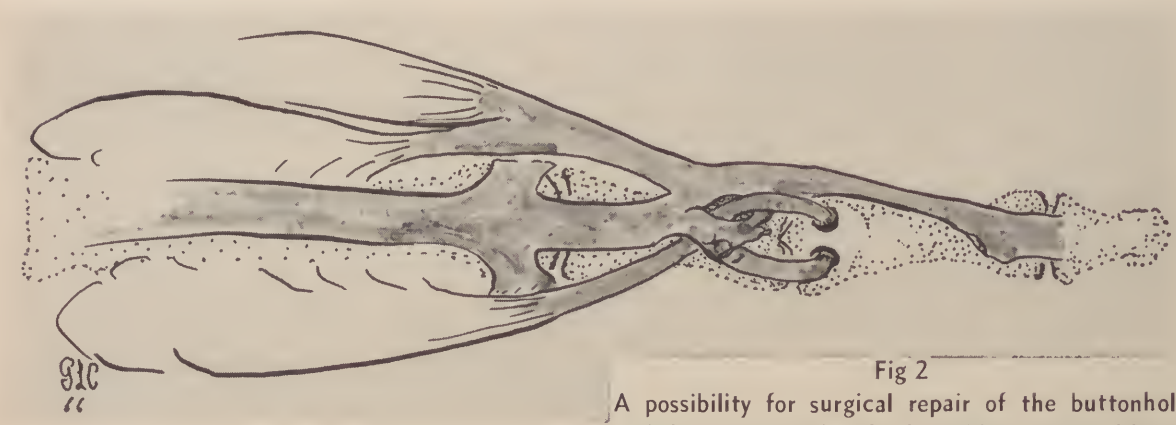


Fig 2
A possibility for surgical repair of the buttonhole deformity described by J. William Littler, MD.

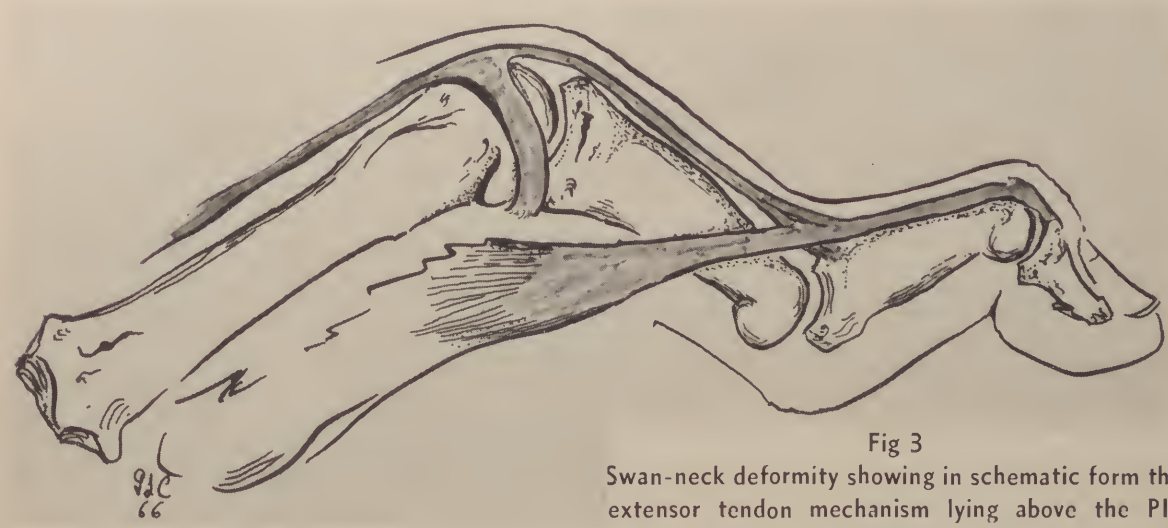


Fig 3
Swan-neck deformity showing in schematic form the extensor tendon mechanism lying above the PIP joint axis.



Fig 4
Swan-neck deformity in a rheumatoid finger with subluxation of the MP joint and articular surface damage.

mon. Properly selected cases respond well to surgical repair. One should be alert for the surgically correctable abnormalities.

Synovitis of the Metacarpal-Phalangeal (MP) Joint:

Figure 6 shows the hand of a patient with rheumatoid arthritis who has extensive synovitis of the MP joints. The proliferating synovium appears to be the immediate cause of destruction of the joint and surrounding tissues. Surgical removal of the synovium results in the slowing down or arrest of destruction of the joint. Figures 7 to 10 illustrate Dr. Vainio's method of arthroplasty of the MP joint. Synovectomy may be performed during this operation of necessary.

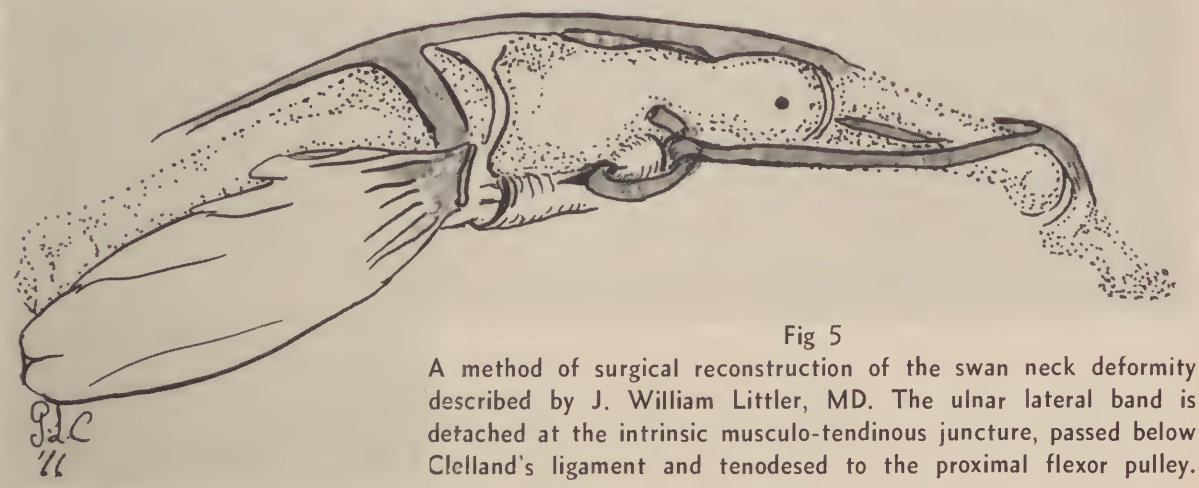


Fig 5
A method of surgical reconstruction of the swan neck deformity described by J. William Littler, MD. The ulnar lateral band is detached at the intrinsic musculo-tendinous juncture, passed below Clelland's ligament and tenodesed to the proximal flexor pulley.



Fig 6—Above
The Vainio Arthroplasty: A rheumatoid hand with synovitis of the MP joints and ulnar drift.



Fig 7—Right
Through a transverse incision, the MP joints are exposed by opening the extensor hood. Note that the extensor tendons have migrated into the ulnar valleys between the metacarpal heads.

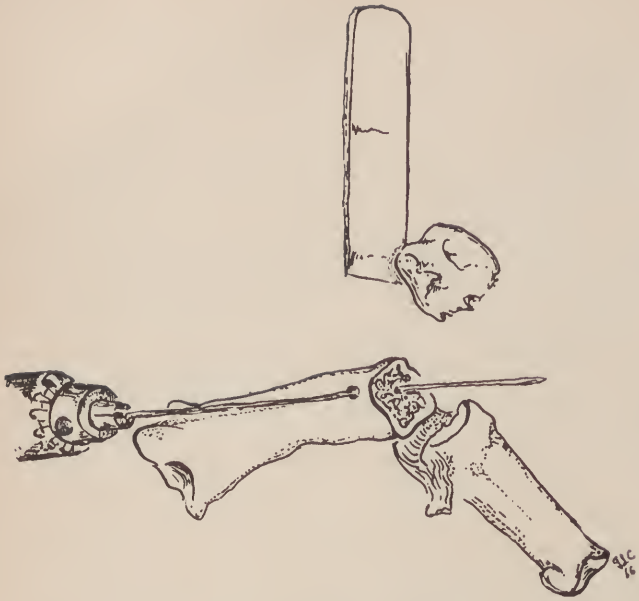


Fig 8

Once exposed, the metacarpal head is excised with a sharp osteotome. A synovectomy is performed and a drill hole for reattachment of the radial collateral ligament is made in the dorsal radial aspect of the metacarpal with a Kirschner wire. The volar plate is left undisturbed.

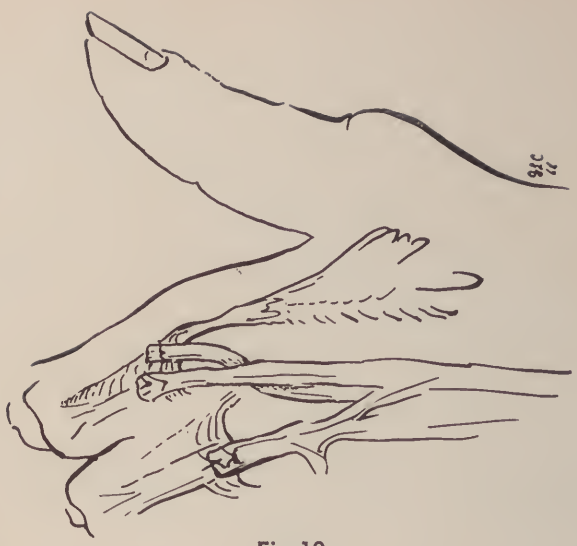


Fig 10

Following the extensor tendon repair on the index finger, the extensor indicis proprius is passed underneath and sutured into the first dorsal interosseous mechanism to add a corrective force to prevent ulnar drift. At the completion of surgery the hand is immobilized for three weeks in a functional attitude; then active exercises are begun. No corrective splinting is used.



Fig 9

The common extensor tendon is divided at the arthroplasty level allowing adequate length on the distal stump for suturing into the volar plate. The proximal tendon stump is then sutured onto the extensor mechanism over the proximal phalanx. The radial collateral ligament is then attached to the metacarpal neck with one suture through the previously made drill hole. The extensor tendon is then replaced over the apex of the joint as shown in the end-on view of the metacarpal at the bottom of the figure.

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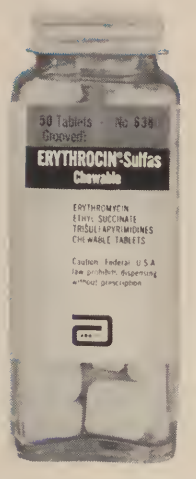
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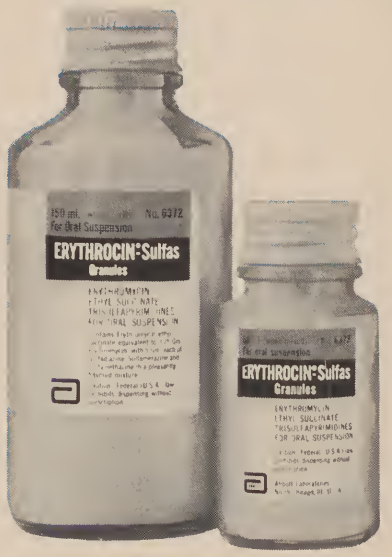
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In clinical trials[1,2], this orange-flavored tablet was given to 55 patients, aged four months to 18 years.

Diagnoses (multiple in some cases) represented a cross section of bacterial infections commonly seen in pediatric office practice.

Therapy was given from three to 12 days, with an average of six days.

Of the 55 patients, 30 were reported cured within 72 hours, while 22 showed partial recovery within the same time, and subsequent clinical cure.

A clinical cure rate of 94.5%

ERYTHROCIN®-SULFAS Granules (Erythromycin ethyl succinate-trisulfapyrimidines granules for oral suspension)

87 patients were treated[1,2]—all children, ages four months to 15 years.

The diagnoses were multiple in some cases and were chiefly bacterial infections of the respiratory tract.

Dosage was maintained from three to 10 days; average treatment was five days. All of the ill children accepted the orange-flavored suspension favorably.

53 were clinically cured within 72 hours, while 32 showed partial relief within the same time, and subsequent clinical cure.

701358

A clinical cure rate of 97.7%

1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

ABBOTT

Brief Summary on next page

ERYTHROCIN®-SULFAS
Brief Summary

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or newborn infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. of each of sulfadiazine, sulfamerazine and sulfamethazine.

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701358

mudrane®

for

- EMPHYSEMA
- ASTHMA
- CHRONIC BRONCHITIS
- BRONCHIECTASIS

The fast-disintegrating uncoated tablet gives relief in 15 minutes

Each tablet contains:

Potassium Iodide	195 mg.
Aminophylline	130 mg.
Phenobarbital, Caution: May be habit forming...	21 mg.
Ephedrine HCl	16 mg.

FEDERAL LAW PROHIBITS
DISPENSING WITHOUT PRESCRIPTION

Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

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Manufacturers of ethical pharmaceuticals since 1856



"Livingston... vertigo is my doom!"
Cried Stanley in his doctor's room.





Said the doc, "For your ills
I've got just the pills."



Said Stan,
"Antivert, I presume."

Antivert® tablets/syrup stops vertigo
(meclizine HCl, niacin)

Tablets: (meclizine HCl 12.5 mg. and niacin 50 mg.) Syrup: (each 5 cc. teaspoonful contains meclizine HCl 6.25 mg. and niacin 25 mg.)

Most widely prescribed anti-vertigo agent[1] Complete to moderate relief of symptoms in 9 out of 10 patients[2]

Antivert, the leading anti-vertigo product,[1] combines meclizine HCl, an outstanding drug for treatment of vestibular dysfunction, with niacin, a drug of choice for prompt vasodilation. Prescribe Antivert for your patients with vertigo, Meniere's syndrome and allied disorders.

Precautions and contraindications: Frequent, short-lived reactions include: cutaneous flushing, sensations of warmth, tingling and itching, burning of skin, increased gastrointestinal motility, and sebaceous gland activity. In explaining these reactions to the patient, it is suggested that they be regarded as a desirable physiological sign that the niacin is carrying out its intended function of vasodilation. Because of this vasodilation, severe hypotension and hemorrhage are obvious contraindications to Antivert therapy. Although the incidence of drowsiness and other atropine-like side effects such as dry mouth and blurring of vision is low, the physician should alert the patient to the need for due precautions when engaging in activities where alertness is mandatory. **Use in women of childbearing age:** A review of available animal data reveals that meclizine exerts a teratogenic response in the rat. In one study a dose of 50 mg./kg./day (50 times the maximum recommended human dose) produced cleft palate in 2 of 87 fetuses when administered to the rat at critical times during the first 15 days of gestation. At doses of 125 mg./kg./day, meclizine will produce 100% incidence of cleft palate in the rat. At doses of 25 mg./kg./day, decreased calcification of the vertebrae and relative shortening of the limbs were also produced in the rat, but experts disagree as to whether this is a teratogenic response. While available clinical data are inconclusive, scientific experts are of the opinion that this drug may possess a potential for adverse effects on the human fetus. Consequently, consideration should be given to initial use of a nonphenothiazine agent that is not suspected of having a teratogenic potential. In any case, the dosage and duration of treatment should be kept to a minimum. **Dosage:** One tablet or one to two teaspoonfuls (5-10 cc.) t.i.d. just before meals. Specific requirements for individual patients should be determined by the physician. **Supplied:** Tablets in bottles of 100 and 500. Syrup in pint bottles. RX only.

References: 1. Based on 1966 data from independent physicians' market survey organization. 2. Scal, J. C.: Eye Ear Nose & Throat Month. **38**:738 (Sept.) 1959.

Neobon®
geriatric + supplement

helps keep them 'on the go'

Each capsule contains:

(1) **Vitamins and Minerals**	
Vitamin A (acetate)	2000 U.S.P. units
Vitamin D (ergocalciferol, U.S.P.)	200 U.S.P. units
Vitamin B_1 (thiamine mononitrate, U.S.P.)	0.5 mg.
Vitamin B_2 (riboflavin, U.S.P.)	0.5 mg.
Vitamin B_6 (pyridoxine HCl, U.S.P.)	0.5 mg.
Niacinamide, U.S.P.	50 mg.
Calcium pantothenate, U.S.P.	5 mg.
Vitamin E (di-alpha tocopheryl acetate)	5 I.U.
Rutin	5 mg.
Cobalt (from cobalt sulfate)	0.033 mg.
Molybdenum (from sodium molybdate)	0.066 mg.
Copper (from copper sulfate)	0.33 mg.
Manganese (from manganese sulfate)	0.33 mg.
Magnesium (from magnesium sulfate)	2 mg.
Iodine (from potassium iodide)	0.05 mg.
Potassium (from potassium sulfate)	1.66 mg.
Zinc (from zinc sulfate)	0.4 mg.
(2) **Hematopoietic Factors**	
Iron (from ferrous sulfate)	3.40 mg.
Vitamin B_{12} (cobalamin concentrate, N.F., as Stablets®)	1 mcg.
Vitamin C (ascorbic acid, U.S.P.)	50 mg.
(3) **Digestive Enzyme**	
Pancreatic substance*	50 mg.
(4) **Gonadal Hormones**	
Methyltestosterone, N.F.	1.0 mg.
Ethinyl Estradiol, U.S.P.	0.006 mg.
(5) **Amino Acids**	
L-lysine (monohydrochloride)	50 mg.
L-Glutamic acid	30 mg.

*Enzymatically active defatted material obtained from 250 mg. of whole fresh pancreas.

For older adults who require it, daily supplementation with Neobon can help overcome decreases in endogenous gonadal hormone production, as well as deficiencies of iron, vitamins and other nutritional factors. In a single convenient capsule, Neobon provides vitamins, minerals, gonadal hormones, hematopoietic factors, digestive enzymes, and amino acids—all selected for adjunctive therapeutic value in the geriatric syndrome. For example, one of the gonadal hormones in Neobon is ethinyl estradiol. It is more slowly metabolized in the body than natural estrogens or their esters.

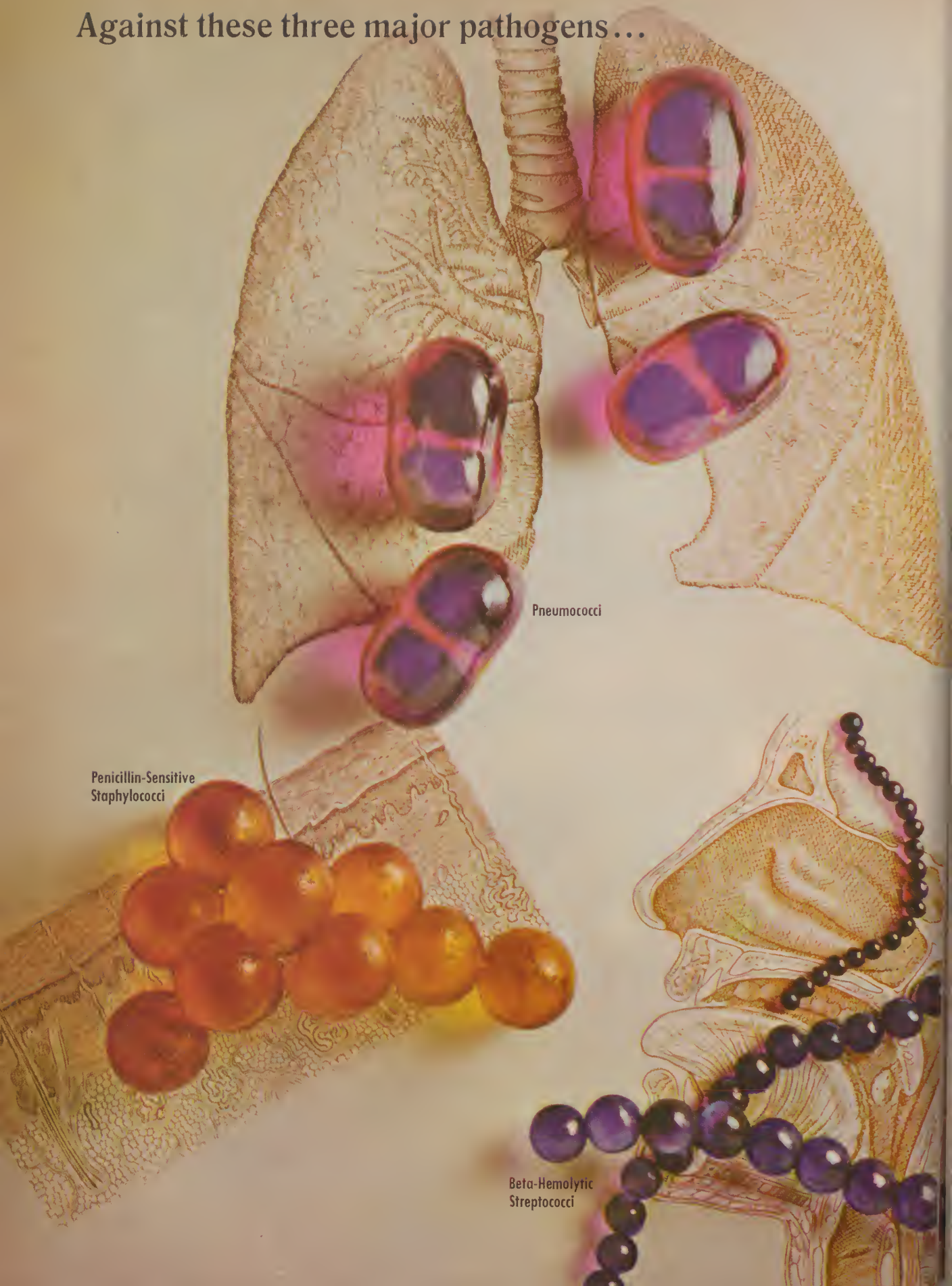
Precautions: Contraindicated in patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast or prostate.

Dosage: One capsule, t.i.d. with meals, or as directed by physician.

Supplied: Bottles of 60 capsules. Rx only.

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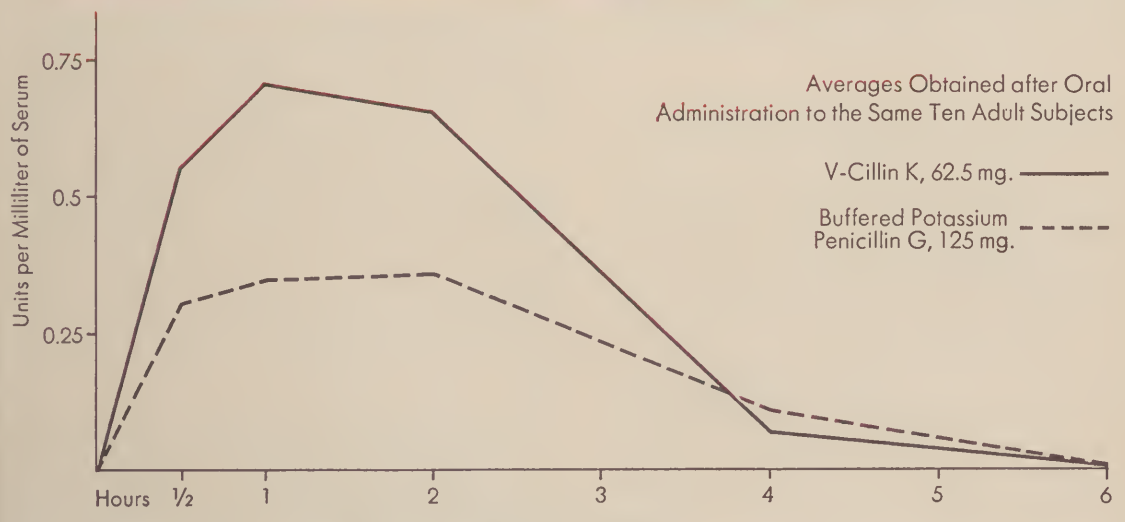
V-Cillin K® provides dependable oral antibacterial activity

because it combines a high degree of in-vitro activity...

Antibiotic	Staph. Aureus (Penicillin-Sensitive) MIC (mcg./ml.) Median	Range	Streptococcus, Group A MIC (mcg./ml.) Median	Range	Diplococcus Pneumoniae MIC (mcg./ml.) Median	Range
Penicillin V	0.02	0.02-0.04	0.02	0.003-0.4	0.01	0.005-0.2
Penicillin G	0.02	0.005-1.6	0.005	0.002-0.2	0.02	0.01-0.1
Methicillin	1.6	0.4-6.3	0.2	0.1-0.4	0.2	0.1-1.6
Oxacillin	0.4	0.1-3.1	0.04	0.02-0.4	0.1	0.04-0.8
Cloxacillin	0.2	0.2-0.8	0.1	0.1-0.8	—	—
Nafcillin	0.4	0.2-0.8	0.04	0.02-0.1	0.02	0.02-0.2
Ampicillin	0.2	0.1-0.8	0.02	0.01-0.04	0.02	0.01-0.04

Adapted from Klein, J. O., and Finland, M.: New England J. Med., 269:1019, 1963.

with high blood levels, even in the presence of food



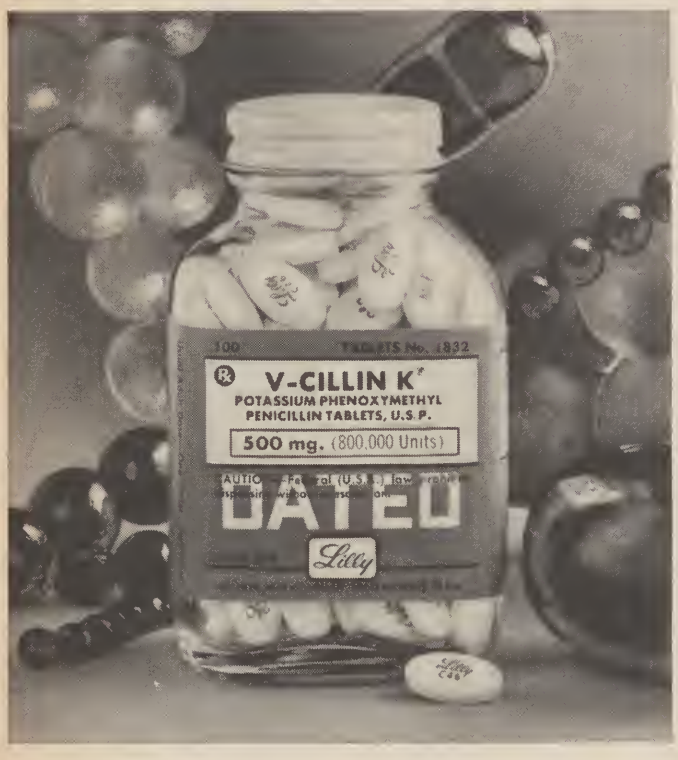
Adapted from Griffith, R. S., and Black, H. R.: Current Ther. Res., 6:253, 1964.

V-Cillin K® Lilly 700636

Potassium Phenoxymethyl Penicillin

(See next page for prescribing information.)

New 500 mg. tablets...a more convenient way to give high doses



Description: V-Cillin K is the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly). This chemically improved form combines acid stability with immediate solubility and rapid absorption. Higher serum levels are obtained more rapidly with this penicillin than with equal oral doses of penicillin G. The higher serum levels and acid stability of V-Cillin K make it a more dependable penicillin for oral use.

V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

Indications: V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Warnings: In rare instances, the use of penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin and in those with bronchial asthma or other allergies. Resuscitative drugs should be readily available for emergency administration. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for relief of immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, its administration should be discontinued, and appropriate measures should be taken.

Adverse Reactions: Although serious allergic reactions are much less common with administration of oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it does possess a significant index of sensitization. The following hypersensitivity reactions associated with the use of penicillin have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: For Tablets V-Cillin K and for V-Cillin K Pediatric, the usual dosage ranges from 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants the daily dosage may be 50 mg. per Kg. of body weight divided into three doses.

Beta-hemolytic streptococcus infections without associated bacteremia may be treated with 200,000 to 400,0000 units three times a day. Therapy should be continued for a minimum of ten days to prevent development of rheumatic fever and/or other serious complications. Dosage for routine streptococcus prophylaxis in patients with a history of rheumatic fever or congenital heart disease may be 200,000 units once or twice daily. When such patients undergo tonsillectomy, tooth extraction, or other minor surgery, the prophylactic dose should be 500,000 units every six hours given two days prior to surgery and for two days postoperatively. If oral medication is not feasible on the day of surgery, parenteral therapy should be considered. Mild to moderately severe pneumococcus pneumonia has been treated effectively with 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be given every six to eight hours in conjunction with indicated surgical procedures.

For gonorrhea in males, 500 mg. (800,000 units) every four hours for three doses may be employed; in females, 500 mg. every four hours for six doses are recommended. Patients with a suspected lesion of syphilis should have a dark-field examination before receiving penicillin and monthly serologic tests for a minimum of three months.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units) in bottles of 50 and 100; and 250 mg. (400,0000 units) and 500 mg. (800,000 units), in bottles of 24 and 100.

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,0000 units) per 5 cc. of solution, in 40, 80, and 150-cc.-size packages. [011867]

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

Lilly

Pediatrics

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RAY HEPNER, MD, Editor

Medical Genetics

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Somatic Cell Genetics
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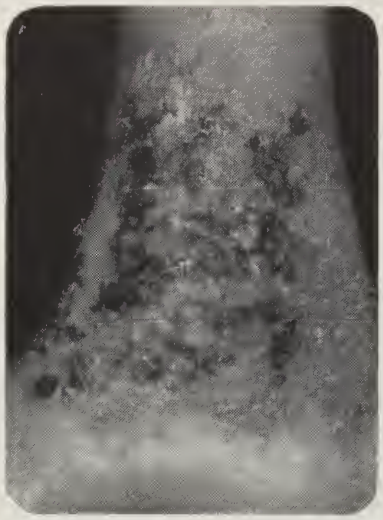
In recent years there has been an increasing interest in those diseases which are genetically and chromosomally transmitted. Both medical and lay publications have reflected this concern and patients are becoming more aware of the implication of the often heard statement, "It runs in the family." Another indication of this trend is the increasing number of training programs in medical genetics. The question arises then as to what is the role of the medical geneticist or, perhaps of more pragmatic interest, what does he or she have to offer to the practicing physician.

Medical genetics is populated by a group of people with a wide variety of training and research interests. They may be internists, pediatricians, hematologists or PhDs in human genetics. Research interests vary from population genetics to biochemical genetics to pharmacogenetics to cytogenetics, etc. The area of clinical concern is genetic prognosis and counseling.

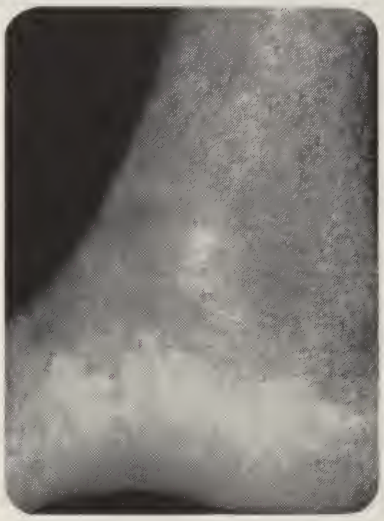
Genetic prognosis deals with predicting the probability of recurrence of an hereditary disease in future offspring of relatives or parents of an affected child. The first step is obviously to ascertain the correct diagnosis. To do this, the medical geneticist requires a careful and detailed personal and family history and physical examination not only of the patient but also of other family members. He also may need certain routine laboratory studies and additional special studies such as buccal smears for sex chromatin, chromosomal studies, dermatoglyphics, urinary and/or serum amino acid determinations, urinary mucopolysaccharides, etc. Once the diagnosis is made, other problems arise. In those disorders which are caused by a single mutant gene, prognosis may be very exact and a definite numerical recurrence can be cited. In many developmental anomalies, such as cleft lip and/or palate, prognosis becomes much more empiric. Very rarely, this anomaly may be associated with a chromosomal error, ie the D1 trisomy. It may even be inherited as an autosomal dominant trait, but more usually this is not the case. Usually, the child is quite normal otherwise and may or may not have an affected relative. In this well-studied condition, empiric risk figures may range from 0.1% if neither parent nor any siblings are affected to 10%-15% when one parent and one sibling are affected. These percentages are based on results obtained in large studies of the incidence within families of this malformation. Moreover, even in some single gene disorders (especially in dominant diseases), a gene may not express itself until late in life or may never be expressed at all. This variety of gene expression must be taken into account in dealing with examples where a disease "skips" a generation.

It is not the purpose of this paper to describe genetic risks in detail or to list genetic syndromes. Several excellent texts on these subjects, and a

Eczema of many years... controlled in two weeks



Before treatment



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with ARISTOCORT Topical
Ointment 0.1% for two weeks

ARISTOCORT® Triamcinolone Acetonide Topicals have proved exceptionally effective in the control of various forms of eczema: allergic, atopic, nummular, psoriatic, and mycotic.

In most cases responsive to topical ARISTOCORT, the 0.1% concentration is sufficiently potent. The 0.5% concentration provides enhanced topical activity for patients requiring additional potency for proper relief.

Administration and Dosage: Apply sparingly to the affected area 3 or 4 times daily. Some cases of psoriasis may be more effectively treated if the 0.1% Cream or Ointment is applied under an occlusive dressing.

Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

Available in 5 Gm. and 15 Gm. tubes and ½ lb. jars.

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Aristocort® Topical Ointment 0.1% and Cream 0.1%, 0.5%
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number of pertinent articles, will be listed at the end. It is the intention of this writer to point out that the burden of genetic counseling rests on the private practitioner. It is he who must recognize the disorder and that it is of genetic origin. In many instances, he will do his own counseling. This is obviously preferable for he knows the family, has rapport with them, and can best evaluate the impact that genetic counseling will have on them. In instances of obscure disorders which he refers to a medical geneticist, he must be the one who reinforces and, many times, explains the recurrence risks to the often bewildered parent.

Finally, we would like to emphasize that, where as we have the obligation to provide patients with true genetic prognosis to the best of our ability, we do not have the right to decide for them whether or not to have additional children. That is their decision to make. One-in-four risks mean different things to different people and the gambler reacts differently from the arch conservative.

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HAMPDEN



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. . . . . .
FOR MOVING & STORAGE
CH. 3-4750

SUGGESTED READING LIST

Roberts, J. A. F.: *An Introduction to Medical Genetics,* 3rd ed, New York: Oxford University Press, 1965. (An excellent basic introduction)

McKusick, V. A.: *Mendelian Inheritance in Man,* Baltimore: Johns Hopkins Press, 1966. (A catalogue of all known and suspected genetic diseases)

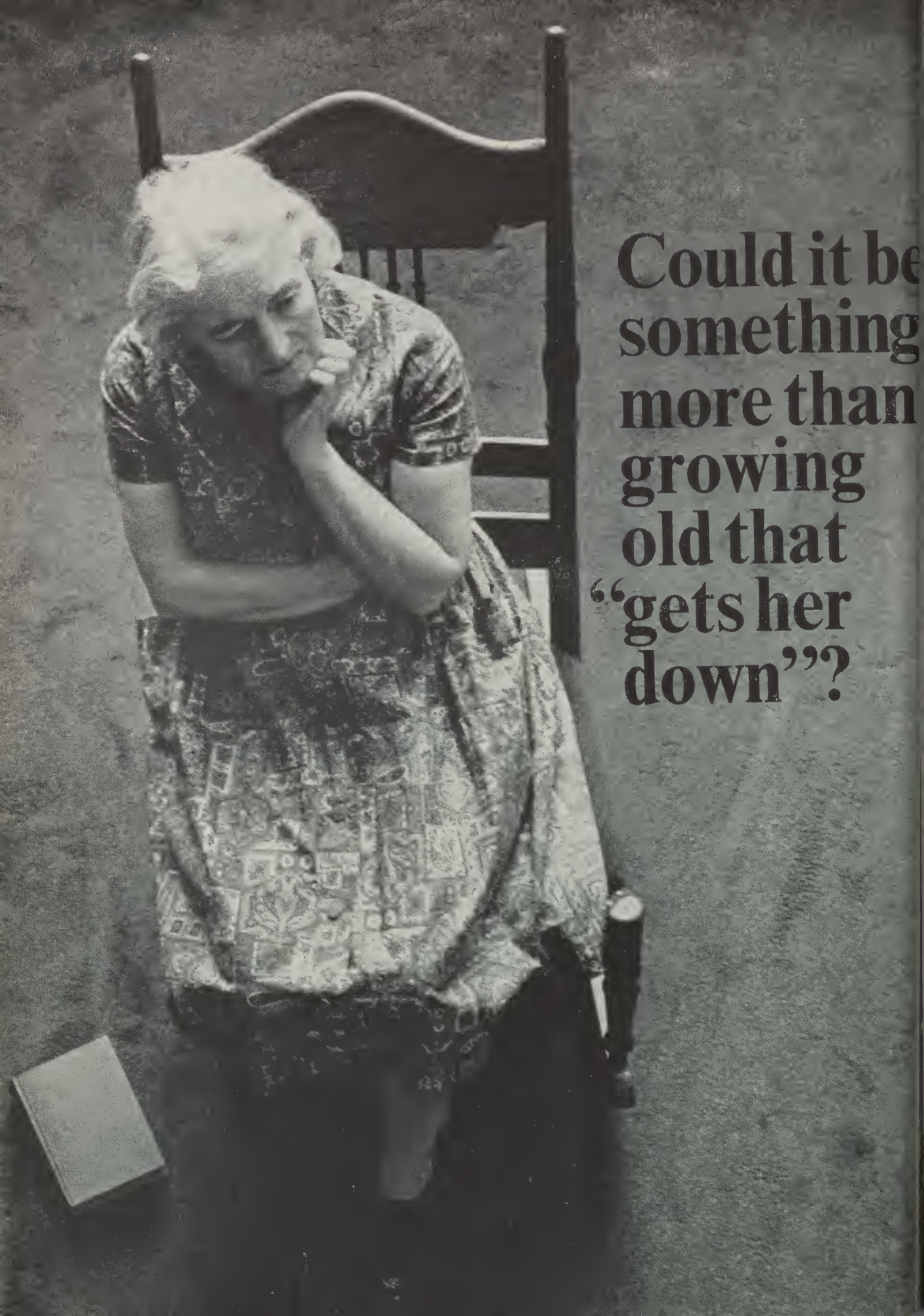
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Could it be
something
more than
growing
old that
"gets her
down"?

Mild mood depression, poor appetite, little interest in the present or future. Does this picture mean that she's giving in to functional fatigue?

When functional fatigue is part of her problem, Alertonic can help counteract accompanying apathy and inertia. It helps lift mood, stimulate appetite, and establish new interest in daily life.

Pleasant-tasting Alertonic combines pipradrol hydrochloride—a gentle cerebral stimulant—with an excellent vitamin and mineral formula, in a satisfying 15% alcohol vehicle.

Especially in the aging patient, nothing fosters confidence and a sense of well-being better than your own personal warmth, understanding, and encouragement. Between visits, however, your prescription for Alertonic can help keep your patient from giving in to functional fatigue.

Adequate dosage is important: Prescribe Alertonic—one tablespoonful t.i.d., 30 minutes before meals ...tastes best chilled.

And for your patient's sake, prescribe Alertonic in the convenient, economical one-pint bottle.

Available only on prescription

Alertonic®

Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%, pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin B_1) (10 MDR*), 10 mg.; riboflavin (vitamin B_2) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin B_6), 1 mg.; niacinamide (5 MDR), 50 mg.; choline,† 100 mg.; inositol,† 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.

Indications: 1. Functional fatigue such as that often associated with: a depressing experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

Contraindications: As with other drugs with CNS stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive compulsive states.

Side effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

Merrell

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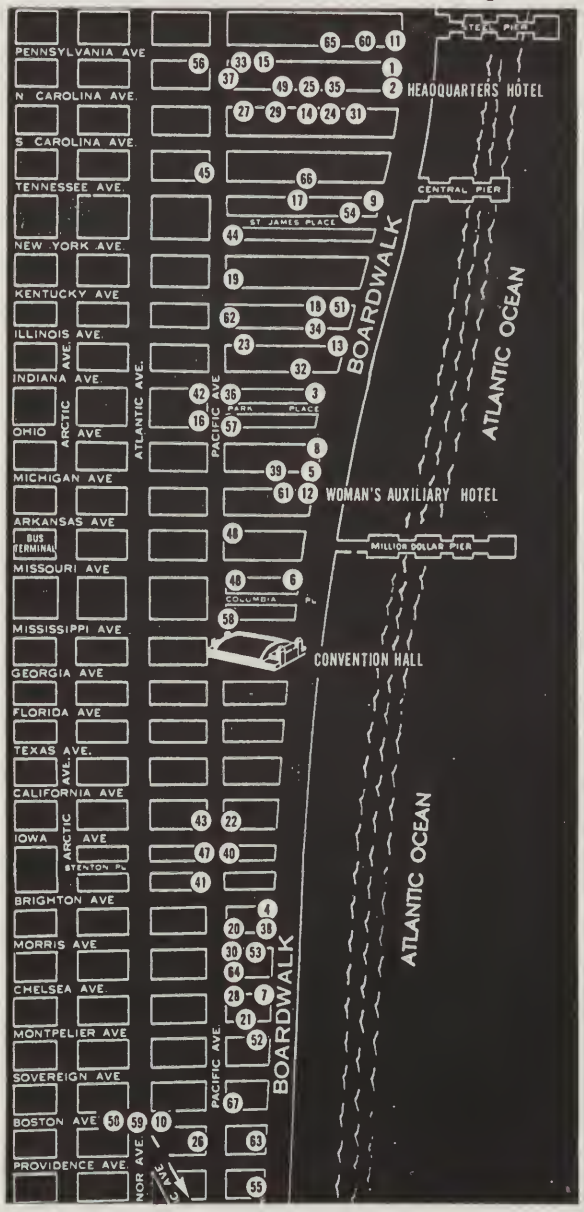
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MAP NO.	BOARDWALK HOTELS	SINGLES	DOUBLES	TWINS	SUITES
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	HADDON FALL*.....	NO ROOMS AVAILABLE)			
3.	CLARIDGE HOTEL*.....	10—26		14—30	58—88
4.	DEAUVILLE HOTEL*.....	14—20		16—28	45—130
5.	DENNIS HOTEL*.....PAC	11—21		15—34	46—95
6.	HOLIDAY INN OF				
	ATLANTIC CITY*.....	12—20	17—19	16—24	40—82
7.	LA CONCHA HOTEL*.....	12—14		16—24	35—75
8.	MARLBOROUGH-BLENHEIM *				
	(Ocean Wing Only).....	21—25		21—25	42
9.	MAYFLOWER HOTEL*.....	8—10	10—12	10—16	20—24
10.	PRESIDENT HOTEL*.....PAC	11—20		11—20	23—50
11.	SEASIDE TOWER HOTEL*.....	12		14—22	44—60
12.	SHELBURNE—				
	EMPRESS HOTEL*.....	(WOMAN'S AUXILIARY HEADQUARTERS)			
13.	TRAYMORE*.....PAC	8—22		10—24	25—100

Map No.	OFF-BOARDWALK HOTELS	Singles	Doubles	Twins	Suites
14.	CAROLINA CREST HOTEL..PAC	10—12	12	12—14	
15.	COLTON MANOR HOTEL*.PAC	12—21		15—24	42—72
16.	EASTBOURNE HOTEL.....PAC	7—9	10	11	
17.	FLANDERS*.....NAC	8	10	14	
18.	STERLING.....PAC	10—12	12—14	12—14	

Map No.	MOTELS	Singles	Doubles	Twins	Suites
19.	ACAPULCO MOTEL.....	12	14	16—20	
20.	ALGIERS MOTEL*.....	12—14	14—16	12—20	45
21.	ALOHA MOTEL.....	14—16		14—28	
22.	ASCOT MOTEL.....	14—16		14—18	
23.	BALA MOTEL.....	12—18		16—24	
24.	BARBIZON MOTEL INN.....	11—13	15	17—23	60
25.	BARCLAY MOTOR INN.....	20—28		20—30	55—65
26.	BLAIR MOTOR INN.....	12—16		16—22	
27.	BURGUNDY MOTEL.....	12—16		16—26	
28.	CARIBE MOTEL.....	10—12	12	14—18	
29.	CAROLINA CREST MOTEL.....	14—16		14—16	
30.	CASTLE ROC MOTEL.....	14	14—20	14—20	40
31.	CATALINA MOTEL.....	14—20		14—18	
32.	COLONY MOTEL*.....	10—22		12—24	45—80
33.	COLTON MANOR MOTEL*.....	22—28		24—30	54—90
34.	CONTINENTAL MOTEL.....	14—16		14—20	
35.	CORONET MOTEL.....	16—22	18—26	16—24	50—60
36.	CRILLON MOTEL.....	16—22		18—24	
37.	CROWN MOTEL.....	14	16	18	
38.	DEAUVILLE MOTEL*.....	14—24		16—32	100—130
39.	DENNIS MOTEL*.....	15—25		15—29	
40.	DIPLOMAT MOTEL.....	10—12		14—24	30—36
41.	DUNES MOTEL.....	16	16—20	16—20	
42.	EASTBOURNE MOTEL.....		16—20	16—24	
43.	ELDORADO MOTEL.....	16		14—18	
44.	ENVOY MOTEL.....	10	12	14—16	
45.	FIESTA MOTEL*.....	14—16		16—22	35
46.	FOUR SEASONS MOTEL.....	14—18		18—24	
47.	GALAXIE MOTEL.....	12—16		10—16	
48.	HOWARD JOHNSONS*.....	14—18	14—18	18—30	44—90
49.	LA FAYETTE MOTOR INN*....	(CO-HQS HOTEL NO ROOMS AVAILABLE)			
50.	LINCOLN-ROOSEVELT				
	BEACH MOTEL.....	16—18		14—20	18—28
51.	LOMBARDY*.....	12—24		14—26	
52.	MALIBU MOTEL.....	12—14		16—20	
53.	MARDI GRAS MOTEL.....	14—16		16—22	25
54.	MAYFLOWER MOTEL*.....	10—12		10—16	
55.	MONTE CARLO				
	BEACH MOTEL.....	11		13—15	
56.	MONTEREY MOTEL.....	14—16	14—16	18—20	
57.	MOUNT ROYAL*.....	12—24		14—26	
58.	PAGEANT				
	MOTOR INN MOTEL*.....	16—20		18—26	40—44
59.	PRESIDENT MOTEL*.....	13—22		13—22	
60.	SEASIDE MOTEL*.....	14		16—22	
61.	SHELBURNE—				
	EMPRESS MOTEL*.....	12—24		14—34	
62.	SORRENTO MOTEL*_____	10—14		16—22	
63.	STRAND OF				
	ATLANTIC CITY MOTEL*___	10—14		13—17	
64.	TEPLITZKY'S MOTEL_____	14		14—18	
65.	TERRACE*_____	14		16—22	
66.	TRINIDAD MOTEL_____	14—16		16—28	
67.	TROPICANA MOTEL_____	8	10—12	14—18	20—24

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Learn To Do Your Part In The Prevention Of Disease

Tuberculin Tests in Schools

The City Health Department is currently tuberculin testing all kindergarten and first grade children who have this year entered public school for the first time. The testing, which is done with parental consent, will involve up to a total of 14,000 children and should be completed by the end of May.

The project now in progress covers all public schools in the City as contrasted with a previous program, conducted in 1964, that involved only first grade children in inner city public schools.

The program will enable the Department to accomplish three purposes: (1) to discover an occasional case of active tuberculosis in children, (2) to uncover the unknown active adult case responsible for the child's reaction, and (3) to establish an infection rate by age in children as a base for future comparison in evaluation of tuberculosis control.

PROGRESS REPORT ON NEW CHILD HEALTH CARE CENTERS

The Comprehensive Children and Youth Pediatric Care Centers in Baltimore City are off to a promising beginning according to Dr. J. L. Rhyne, Director of Child Health Services in the Baltimore City Health Department.

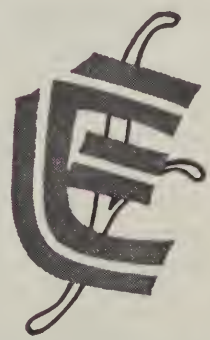
The Sinai-Druid Center at 1515 W. North Avenue registered its 4,352nd patient on March 31 after six months of operation. The Greater Baltimore Medical Center's Children and Youth Project located in the Presbyterian Outpatient Building at 1017 E. Baltimore Street reported a case load of 1,069 patients in its report dated April 1, 1967; the University of Maryland Hospital, 1,130. The Johns Hopkins Hospital Project funded under a separate U.S. Children's Bureau grant, has registered approximately 5,000 patients. A total of about 11,551 children have therefore, been registered for care in these centers in the City of Baltimore. The center at Baltimore City Hospitals will begin to see patients about July 1, 1967. An additional center is being planned at the Union Memorial Hospital.

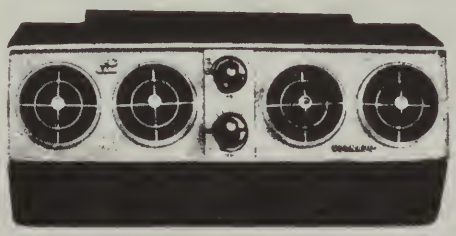
A wide range of screening, diagnostic and treatment services are provided. These include medical, nursing, dental, psychological, nutritional, social, physical therapy and rehabilitation, as well as speech, hearing and vision services which are offered to those eligible children whose families cannot affort private care. These facilities are developing family-centered medical care services providing counseling to parents and direct services to children from birth through 18 years who reside in the designated service areas.

Patients are seen on each visit by the same medical and auxiliary personnel assuring continuity of care; however, the number of broken appointments is of major concern to the centers and steps are being taken to improve this situation. The Sinai-Druid and the Greater Baltimore Medical Center projects are doing an exceptional job in coordinating many existing community agencies which serve children and youth. Weekly case conferences are held, to which representatives of agencies involved in the care of a particular patient are invited. The City Department of Public Welfare, the Baltimore City Public Schools, and the Community Action Agency as well as other community agencies have been particularly

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cooperative in the developmental stages of these new health centers.

We believe that one of the most decisive factors affecting the educational and economic status of a population relates to that population's level of health. Therefore, in addition to providing direct preventive, diagnostic and treatment services, the Comprehensive Health Centers are directing their efforts toward the modification of those community conditions which adversely affect health.

Robert E. Farber, MD
Commissoner of Health

DEPARTMENT OF HEALTH
STATE OF MARYLAND
William J. Peeples, MD, MPH, Commissioner

HIGHLIGHTS

PAYMENTS TO PHYSICIANS UNDER MEDICAL ASSISTANCE PROGRAM

In September 1966, the Health Department committed itself to the principle of "usual" and "customary" fee payments to physicians for their services to patients certified eligible for Medical Assistance.

Item D5340 of the *Federal Handbook of Public Assistance Administration* (Medical Assistance Programs under Title 19 of the Social Security Act), states in part: "The requirement for fee structures permits a variety of means which may be used in determining payments to providers of services other than hospitals. An underlying assumption is that adequate financing is available to pay the costs of the medical and remedial care and services included in the plan."

To implement the revised fee structure, the Health Department requested in its budget for fiscal 1968 an increase of approximately $4,400,000 for payments to physicians for services performed in home, office, or nursing home. An additional $4,300,000 was requested to inaugurate payment to physicians for services to hospital inpatients and outpatients.

Cuts made by the Bureau of the Budget and the Governor reduced the home and office program increase to approximately $2,600,000, and the Governor's budget message specified fees of $5 for an office visit, $6 for a home day visit, and $7 for a home night visit. The funds requested to reimburse physicians for services in hospitals were slashed to $1,868,000.

Following discussions with the budget bureau, the Governor's staff, and the Medical and Chirurgical Faculty, the Department in its supplemental budget requested for payment to physicians an additional $510,925 for the home and office program and $2,168,000 for hospital inpatient and outpatient services. However, the Governor's supplemental budget omitted these requests.

It seems clear that the funds appropriated by the Legislature will not suffice for total payment of "usual" and "customary" fees during fiscal year 1968. The Advisory Committee on Medical Care has been asked to study the situation and make recommendations to the State Board of Health and Mental Hygiene.

HEW ALTERS CRITERIA FOR NURSING HOMES UNDER TITLE 19

The US Department of Health, Education, and Welfare has modified its previous requirement that by Jan 1, 1968, nursing homes under Title 19 meet the standards set for extended care facilities under Title 18 (Medicare) in order to qualify for Federal participation in payments.

A set of twelve general standards replace the more rigid Medicare criteria, and the deadline for compliance has been extended to Jan 1, 1969. However, beginning Jan 1, 1968, federal partici-

pation will continue only if the state has determined that the home has the potential to meet the new "skilled nursing home" standards by Jan 1, 1969. If the home fails to comply with the standards by that date, federal participation in payments will cease.

The new standards retain a requirement that a registered nurse supervise nursing services and that registered nurses or licensed practical nurses be on duty as charge nurses around the clock. With the nationwide shortage of qualified nurses, this requirement remains the greatest obstacle for the nursing home to hurdle. However, the requirement that a licensed practical nurse be graduated from a state-approved school has been relaxed to permit her employment as a charge nurse if she "was successfully discharging the responsibilities of a charge nurse on July 1, 1967, . . . [and] has completed training satisfactory to the appropriate state licensing authority."

TRAINING IN GERIATRIC NURSING GIVEN

A month-long- in-service educational program in geriatric nursing was given by the Divisions of Public Health Nursing and Occupational Therapy in cooperation with the Wicomico County Health Department, at the Wicomico Nursing Home in Salisbury.

Participants included several public health nurses from nearby health departments, plus twelve professional nurses and one licensed practical nurse from nursing homes in the area.

REHABILITATIVE NURSING PROCEDURES TAUGHT AT MONTEBELLO

A four-week course in rehabilitative procedure was recently completed at Montebello Hospital by three nursing supervisors from Sacred Heart Hospital. Instruction was given in initial care of the acutely injured to avoid later disabling contractures, as well as methods of caring for chronic disabilities. Methods which have proved highly successful at Montebello in prevention and cure of decubitus ulcers were demonstrated.

Each participant was assigned two patients for the course, and will use the skills learned to train nurses and other hospital staff. The instruction has engendered widespread interest, and it is hoped similar courses may be arranged for supervisory personnel from other Maryland hospitals.

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LABORATORY SCIENTISTS RECEIVE HIGHEST RATING

Two Bureau of Laboratories scientists from the Division of Virology, recently received an "outstanding" performance evaluation, at the completion of a two-week training course in Serologic Methods in Microbiology, given by the Communicable Disease Center of the US Public Health Service.

INFORMATION TO PHYSICIANS ON POISONOUS PLANTS

The Department recently provided the Medical and Chirurgical Faculty with copies of a list of common poisonous plants and their toxic symptoms, to be mailed to members. The list was also distributed to local health departments.

FILM FEATURES HOSPITAL FIRE SAFETY

Ways of tailoring fire safety programs to special needs of hospitals are demonstrated in a 22-minute film, "Fire and Your Hospital," available for loan from the Department. The film illustrates structural safety precautions, and em-

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phasizes the importance of carefully planned and rehearsed fire emergency procedures. Various methods of transporting patients are shown.

MEDICAL "SELF-HELP" SAVES A LIFE

A free 16-hour course in Medical Self-Help, developed by the Public Health Service and administered in Maryland by the Department through local agencies to secondary schools and community groups, has been credited with saving a child's life. Designed to teach emergency procedures in the event of a major disaster when the services of a physician may not be available, the course was given last year to 38,081 Maryland residents, a three-fold increase over the previous year.

Subjects covered are Radioactive Fallout and Shelter, Healthful Living in Emergencies, Artificial Respiration, Bleeding and Bandaging, Fractures and Splinting, Transportation of the Injured, Burns, Shock, Nursing Care of the Sick and Injured, Infant and Child Care, and Emergency Childbirth. The reported rescue resulted from mouth-to-mouth resuscitation in cases of asphyxia.

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MARYLAND ASSOCIATION OF MEDICAL ASSISTANTS

Medical Assistants Week Terminates With Annual Meeting of MAMA

Spiro T. Agnew, Governor of the State of Maryland, proclaimed April 16-21, 1967, as Medical Assistants Week. As was stated in the proclamation, "The Maryland Association of Medical Assistants is a non-profit organization composed of dedicated men and women who work for the betterment of humanity." The governor urged all citizens to recognize the outstanding work rendered by the association.

Medical Assistants Week was highlighted by the Seventh Annual Meeting of the Maryland Association of Medical Assistants held on April 22, at the Holiday Inn, Baltimore. The meeting commenced with registration at 10:45 AM, after which Miss Betty Fern, president of MAMA, welcomed the members of the Baltimore, Wicomico, and Cumberland chapters. The following new officers were elected at the meeting:

President: Nell Chaney, Baltimore chapter, President-elect: Gertrude Gillum, Cumberland chapter, Vice-president: Carol Davis, Baltimore chapter Secretary: Betty Porter, Wicomico chapter Treasurer: John Komber, Baltimore chapter.

Elected also were the delegates to the AAMA convention. They are as follows:

Mabel Young, Cumberland chapter, Dorothy Hartel, Baltimore chapter, Mary Winters, Baltimore chapter.



Nicholas J. Kohlerman, MD

The meeting was adjourned by Miss Fern at 12:30 PM.

After luncheon, the scientific seminar followed with the welcoming address by Harry J. Connolly, MD, president of the Baltimore City Medical Society. Dr. Connolly emphasized the importance of the medical assistant, and offered the assistance of the Medical Society to publicize the activities of the association.

Nicholas J. Kohlerman MD, chief of obstetrics

and gynecology at Church Home and Hospital, was the first speaker. Dr. Kohlerman, whose topic was "Sex," reviewed the many controversial aspects of his subject as they influence the normal life of man from birth until death. During his presentation, he gave a general account of the stages of sexual development and how to remedy and possibly prevent sexual insufficiency. A brief question and answer period following his talk.

Before the next speaker was introduced, there was a short coffee break at which time door prizes were distributed to the lucky winners.

At 3:30 PM, Harvey Felix, information specialist of the Baltimore City Health Department, was introduced to make his presentation on "Venereal Disease." Mr. Felix explained the startling increase in V.D. throughout the country, and the disturbing number of teenagers infected with the disease. Following his talk, a film, which is being incorporated into the sex educaton in many school systems around the country, stimulated many questions, which Mr. Felix answered during the discussion period.

The meeting was followed, at 6 PM, by a cocktail hour and, at 7 PM, by a banquet in the East Ballroom of the Holiday Inn. The banquet began with the invocation given by the Rev. Pope F. Brock, chaplain at Church Home and Hospital. Master of Ceremonies for the evening was J. Morris Reese, MD, outgoing president of the Medical and Chirurgical Faculty of Maryland. During the evening's festivities, Miss Dorothy Hartel, trustee of the American Association of Medical Assistants, installed the newly elected officers at a "candlelight ceremony."

E. T. LISANSKY, MD, SPEAKS TO MEMBERS OF B A M A

E. T. Lisansky, MD, was the guest speaker at the April meeting of the Baltimore Association of Medical Assistants. Dr. Lisansky's topic was Psychosomatic Medicine. The speaker emphasized the importance of psychosomatic treatment in conjunction with physical disease.

Dr. Lisansky is associate professor of medicine and clinical psychiatry at the University of Maryland School of Medicine, and also lectures at the University of Maryland School of Social Work, Dentistry, Nursing, and Law.

MEMBERS OF MAMA ATTENDED SCIENCE FAIR EXHIBIT

Members of MAMA joined the Washington Medical Assistants at the Science Fair Exhibit held on April 15 and 16 at the Coliseum on the University of Maryland campus. The American Association of Medical Assistants' display was exhibited, and members of the association were present to answer questions asked by students and visitors.

MEDICAL ASSISTANTS HELP AT THE HEALTH EVALUATION CENTER AND COFFEE BOOTH

Members of the Maryland Association of Medical Assistants volunteered their services at the annual meeting of the Medical and Chirurgical Faculty of Maryland. The volunteers helped with the health evaluation center and also served coffee to participants at the meeting.



Newly installed officers of M.A.M.A. 1967: (left to right) Carol Davis, vice president; Carolyn Ziolkowski, corresponding secretary; Gertrude Gillum, president elect; John Komber, treasurer; Nell Chaney, pesident.

Solutions to Business Problems in Daily Medical Practice



ALL ABOUT AIDES - PART I

WILBURN L. McCLURE, JR.

Not long ago a well-established physician walked into my office and introduced himself. He had a very definite problem. His secretary-receptionist had resigned.

His questions were, "How do you find a good aide, and how do you know a good one until she has worked in your office for several months? What kind of questions should he ask her? How could he keep her interested enough to stay with him?; and what did he do to make his last aide resign'"

All of these are good questions. This doctor is not the first to be confronted with such a problem.

The following sections answered his questions and will act as a guide toward analyzing the current rapport with your staff.

FINDING AN AIDE

The doctor in question remarked that several of his colleagues were well satisfied with their aides—mentioning how responsible they are, and that they have employed them for many years.

My suggestion was that his successful colleagues would be best able to provide some guidelines.

Each time I encounter an exceptional aide in a client's office, I attempt to find out how he located her, how long she has been with him, his complaints and, his praises.

The consensus seems to be that most physicians locate their aides through the following methods:

1. Colleges—It would certainly be advantageous to hire a college graduate, though few doctors have the foresight to do so. Few doctors want to pay a salary commensurate with what graduates want or deserve. This is unfortunate. With all aspects of medicine becoming more and more involved in administration, law, technical requirements and extensively trained physicians, it is time to upgrade the status of "aides."
2. Junior Colleges—Choose one which has an elective or a regular curriculum in subjects relating to administrative techniques employed in a doctors office. Here students generally are high caliber girls preparing for a career rather than just a job.
3. Professional Schools—Such as an accredited Nursing school attached to a hospital. If an R.N. is needed, the competition will be high and assistance from the administrator cursory. Such schools generally direct their graduates to the hospital or similar institutions connected with the hospital. Success in finding an aide in such a school depends on your personal contacts at the school and in the hospital.
4. Medical Secretarial Schools—Most states have several secretarial schools, training students for work in the field of medicine. Many

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such institutions offer comprehensive medical secretarial courses. A few are taught by practicing physicians who act as professional lecturers. When approaching the placement officer of such an institution, check to see if it is state accredited. Also asked for one of their brochures. This way you can review their curriculum, history, instructors, etc.

5. State, County, or City Medical Assistants Organizations—There is a national organization called the American Association of Medical Assistants. Most states have branch member organizations. Local organizations have some type of placement service or, at least a public relations officer who can assist a physician. The Maryland Association of Medical Assistants provides such a program. Such organizations are best contacted through local medical societies.
6. Professional Counselor—Most physicians have business advisors who should be in a position to provide recommendations concerning the hiring of an aide. If the business consultant is well enough versed with the doctor's requirements, he can assist in weeding out undesirable applicants by contacting schools and agencies and by conducting interviews.
7. Advertising in the newspapers—This is one of the most harassing methods of obtaining an aide. If the doctor advertizes, he is confronted with appointments and interviews. One advantage is a post office box number for replies. One can observe the caliber of typing or handwriting, the completeness of the résumé, the grammar, and the references.
8. Employment Agencies—Agencies specializing in areas such as medical secretaries generally provide adequate assistance to the physician. Very seldom do the agencies bother to interview applicants sufficiently or test them for typing and shorthand abilities. They are quite willing to call and claim the applicant is qualified.

Past experiences have probably dictated that it is not easy to find a good aide. A final resort are the placement officers, employment agencies and newspaper advertizing. Next month, Part II will be discussed which is entitled, "How to Interview a Prospective Aide."



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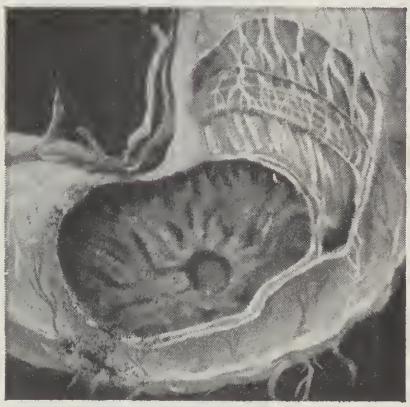
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MAY, 1967 MRS. HARRY L. BERMAN, *Editor*

Woman's Auxiliary Holds Annual Meeting

The 18th Annual Meeting of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland was held April 19 and 20 at the Sheraton-Belvedere Hotel in Baltimore.

Due to unfortunate illness, both Mrs. Archie Cohen and Mrs. Wallace Sadowsky, president and president-elect, respectively, were unable to attend. The presiding officer was first vice-president, Mrs. M. McKendree Boyer.

E. Roderick Shipley, MD, of the Faculty Public Relations Committee, speaking at the general session on April 20, thanked the members for their many services and philanthropic endeavors.

The business meeting was followed by a sherry hour and luncheon, at which J. Morris Reese, MD, president of the Medical and Chirurgical Faculty extended greetings. He was followed by John W. Walsh, MD, who presented an illustrated lecture on the SS HOPE in Colombia.

Honored guests presented were: Mrs. Thomas N. Carter, president of Woman's Auxiliary to the District of Columbia Medical Society, and Mrs. James H. Sculley, its president-elect; Mrs. Hu C. Myers, president, Woman's Auxiliary to the West Virginia Medical Society and Mrs. Rupert Powell, its president-elect; Mrs. Harold Laggoner, president-elect, Woman's Auxiliary to the Delaware Medical Society; and Mrs. Robert F. Beckley, Eastern Regional vice-president of the Woman's Auxiliary to the AMA.



Mrs. M. McKendree Boyer, presiding officer at the Womans' Auxiliary to the Medical and Chirurgical Faculty of Maryland luncheon, seen with J. Morris Reese, MD, president (1966-67)

The invocation was given by Rabbi Donald N. Gluckman.

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Mrs. William S. Stone, president elect to the Womans' Auxiliary seen with Mrs. John W. Walsh, wife of the guest speaker at the luncheon.



Among the guests attending the luncheon: Fron left to right Mrs. William Dunseath, timekeeper WA to the Medical and Chirurgical Faculty of Maryland, Mrs. I. N. Carter, president of WA to BCMS; Mrs. James Scully president-elect to WA District of Columbia, Mrs. J. Edwin Kunze, secretary to the late J. Mason Hundley Jr. MD., Mrs. Robert Rosensteel, president-elect WA SAMA, Mrs. Karl F. Mech, credentials chairman to WA, Mrs. Robert France, president WA-SAMA and Mrs. Albert E. Goldstein, chairman WA-SAMA.

Mrs. Leonard Warres, president-elect; Mrs. Raymond M. Yow, first vice-president; Mrs. R. C. V. Robinson, second vice-president; Mrs. Carlton Brinsfield, third vice-president; Mrs. Henry P. Laughlin, fourth vice-president; Mrs. Roy Skipton, recording secretary; Mrs. S. G. Sullivan, treasurer; Mrs. George S. Malouf, corresponding secretary; and Mrs. Martin S. Strobel, parliamentarian.



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The officers for 1967-68 were installed at the monthly meeting of the Woman's Auxiliary to the Montgomery County Medical Society. It was held at the Manor Country Club on May 16th at 11:30 A.M.

The women filling these positions are as follows: President, Mrs. John B. Umhau, Jr., President-elect, Mrs. Gordon Smith, vice president, Mrs. Francis C. Mayle, corresponding secretary, Mrs. Albert Zelna, recording secretary, Mrs. Crawford S. Brown, treasurer, Mrs. John O. Robben, assistant treasurer, Mrs. Solomon Barr, parliamentarian, Mrs. Andrew J. Brennan.

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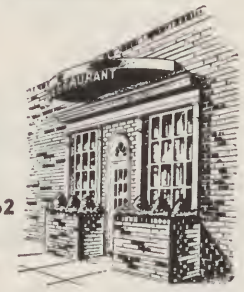
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The following is a brief precautionary statement. Before prescribing, the physician should be familiar with the complete prescribing information in SK&F literature or *PDR*. *Contraindications:* Comatose states or the presence of large amounts of C.N.S. depressants. *Precautions:* Potentiation of C.N.S. depressants may occur (reduce dosage of C.N.S. depressants when used concomitantly). Antiemetic effect may mask other conditions. Possibility of drowsiness should be borne in mind for patients who drive cars, etc. In pregnancy, use only when necessary to the welfare of the patient. *Side Effects:* Occasionally transitory drowsiness; dry mouth; nasal congestion; constipation; amenorrhea; mild fever; hypotensive effects, sometimes severe with I.M. administration; epinephrine effects may be reversed; dermatological reactions; parkinsonism-like symptoms on high dosage (in rare instances, may persist); weight gain; miosis; lactation and moderate breast engorgement (in females on high dosages); and less frequently cholestatic jaundice. Side effects occurring rarely include: mydriasis; agranulocytosis; skin pigmentation, lenticular and corneal deposits (after prolonged substantial dosages).

For a comprehensive presentation of 'Thorazine' prescribing information and side effects reported with phenothiazine derivatives, please refer to SK&F literature or *PDR*.

Smith Kline & French Laboratories SK&F

Maryland
STATE MEDICAL JOURNAL

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June, 1967

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Annual Meeting—New York Hilton Hotel. Contact: Miss Morgoret M. Walsh, 1212 Avenue of the Americas, New York, N. Y. 10036.

AMERICAN RHEUMATISM ASSOCIATION

June 16-18

72nd Annuol Meeting—Corolina Hotel, Nogs Heod. Contact: Jerome E. Adamson, MD, 603 Medicol Towers, Norfolk, Vo. 23507.

SEABOARD MEDICAL ASSOCIATION

June 17

Ninth Annual Meeting ot Colony Resort, Atlantic City, N. J. Contact: Seymour Diamond, MD 5214 North Western Avenue, Chicogo, Ill. 60625.

AMERICAN ASSOCIATION FOR THE STUDY OF HEADACHE

June 18-22

Generol Scientific sessions on Potient Care, Backache, Heoling, and Sex; symposia at individuol or joint meetings of the 22 Scientific sections; medical motion pictures; ond live color television programs. See JAMA May 8, 1967, for complete scientific progroms, forms for odvonce registration ond hotel occommodotions.

116th ANNUAL AMA CONVENTION

June 18—7:30 PM

Ninth Annual Pre-Convention session on School Health. Chalfonte-Haddon Hall. Contact: Deportment of Heolth Education, Division of Socio-Economic Activities, Americon Medicol Associotion. 535 North Dearborne St. Chicogo, Ill. 60610.

AMA DEPARTMENT OF HEALTH EDUCATION

June 23-25

Week End with Doctors. Western Moryland College, Westminster, MD. Contoct: 415 North Chorles Street, Baltimore, MD. 21201.

HEART ASSOCIATION OF MARYLAND

August 14-18

Golden Anniversory Meeting. Conrod Hilton Hotel. Contact: The American Dietetic Associotion 620 North Michigan Ave. Chicago, Ill. 60611.

THE AMERICAN DIETETIC ASSOCIATION

September 8-9

Semionnual meeting. Medicol ond Chirurgicol Foculty of the Stote of Morylond, Oceon City.

MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND SEMIANNUAL MEETING

September 21-24

27th Annuol Meeting of the Americon Medical Writers Associotion. Palmer House, Chicago. Contact AMWA, Post Office Box 267, Arlington, Vo. 22210.

AMERICAN MEDICAL WRITERS ASSOCIATION

October 2-4

37th Annuol Fall Conference. Sheroton Oklohomo Hotel. Contoct: Almo O'Donnell 2809 Northwest Expresswoy Oklohoma City 73112.

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Recently Modell[2] has stated: "The mercurial diuretics are the injectable diuretics of choice since they are the most potent as well as the most dependable. Their toxicity is not an important consideration either by comparison with other potent diuretics or in relation to the seriousness of the conditions in which they provide such excellent relief."

IN BRIEF

Mercuhydrin is indicated in edema of cardiac or hepatic origin and in the nephrotic syndrome; it is contraindicated in acute nephritis and in anuric or oliguric states. *The usual adult dose is one to two cc. daily or every other day until "dry weight" is obtained.* Sensitivity is rare but small initial doses are advised to minimize potential reactions; vertigo, fever, and rash have occurred. Overdosage may produce electrolyte depletion, muscle cramps, and G. I. reactions. Supplied: 1 cc. and 2 cc. ampuls in boxes of 12, 25 and 100; 10 cc. rubber capped, multiple-dose vials (intramuscular or subcutaneous use only) in boxes of 6 and 100.

1. Gold, Harry, *et al.: A System for the Routine Treatment of the Failing Heart,* The American Journal of Medicine, Vol. III, No. 6:665-692 (Dec.) 1956.

2. Modell, Walter: *Drugs of Choice 1966-1967,* p. 97, 1966.

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PRECAUTIONS: (1) Outpatient use of desipramine hydrochloride should not be substituted for hospitalization when risk of suicide or homicide is considered grave. (2) If serious adverse effects occur, reduce dosage or alter treatment. (3) In patients with manic-depressive illness a hypomanic state may be induced. (4) Discontinue drug as soon as possible prior to elective surgery.

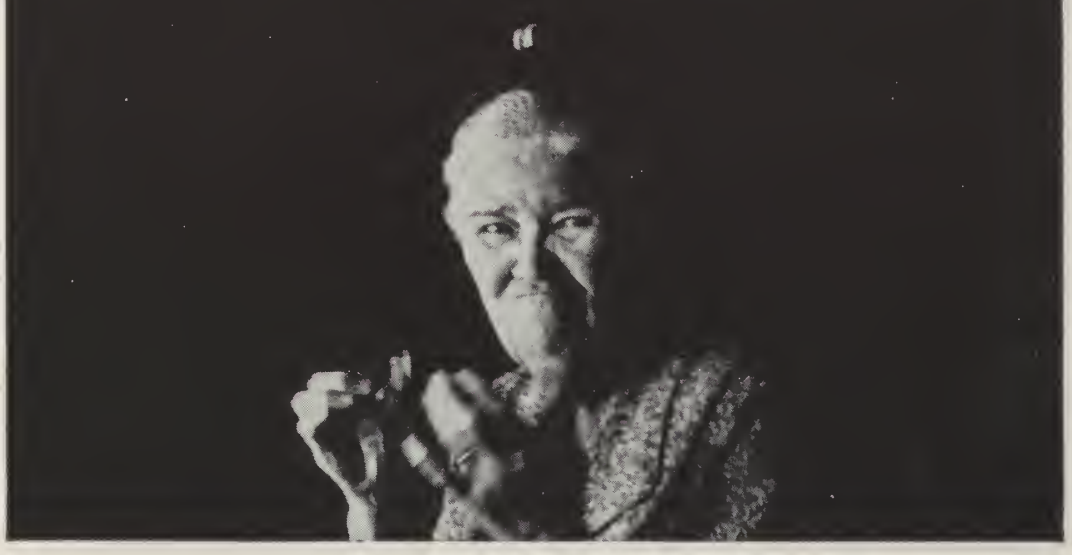
ADVERSE EFFECTS: Side effects, usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, anxiety, agitation and stimulation, insomnia, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, tremor, allergy, agranulocytosis, altered liver function, ataxia, and extrapyramidal signs.

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SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

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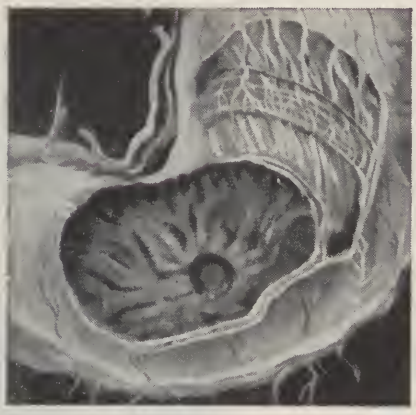
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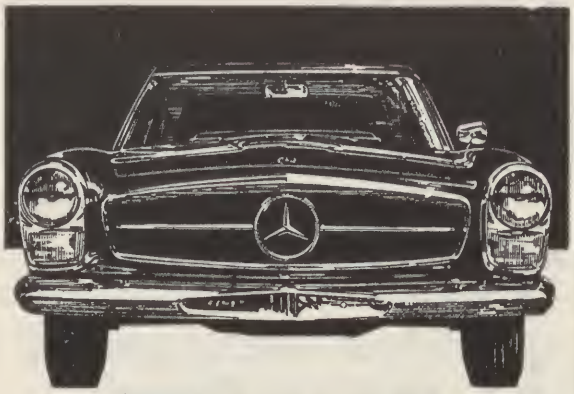
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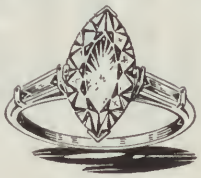


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EXECUTIVE SECRETARY'S NEWSLETTER

June, 1967

1967 DIRECTORY

The 1967 Directory issue of the Maryland State Medical Journal soon goes to press. If you have not returned your listing for 1967 - or have not received one - check your current listing and advise of any changes that should be carried. Such advice should be in writing and sent to the Faculty office without delay.

1967 LEGISLATION

In the latest issue of The Assemblyman, reference is made to Work Permits for Minors. The effective date of this legislation is June 1, 1967.

In addition, comment was received regarding Senate Bill 189, dealing with the prohibition on "...dispensing...of amphetamines or barbiturates...to minors." Physicians are not affected by this legislation, inasmuch as a previous section of the law specifically covers this aspect when in the normal practice of their profession.

NEWS NOTES

J. Fred Hawkins, M.D., Annapolis, has moved his office to the Lyons Professional Building, 16 Murray Avenue.

George H. Yeager, M.D., Baltimore, has been named to the Council of the Southern Medical Association.

Gilbert D. Barkin, M.D., Silver Spring, has been elected to serve as Vice Chairman, Section on Allergy, Southern Medical Assn.

David Marine, M.D., has been chosen as the President of the Maryland Thoracic Society; while Mary Avery, M.D., will serve as Vice-President; C. Murray Wylie, M.D., will act as Secretary-Treasurer.

Others elected include Allan S. Moodie, M.D., and Milton B. Kress, M.D., as members of the Executive Committee; and John Miller, M.D., as the Councilor to the American Thoracic Society.

John Wiswell, M.D., has been named Professor of Medicine; and Drs. Harold C. Dix and Albert Steiner, Clinical Assistant Professors of Otolaryngology, at the University of Maryland School of Medicine.

Peter A. Santucci, M.D., was elected Vice-President of the Guild of Catholic Psychiatrists at their Annual Meeting on May 8.

DRUG SAMPLES

One of the many worth-while projects of the Faculty's Auxiliary is that of collecting unneeded drug samples and distributing, after sorting and collating, to various needy charitable projects. These include Operation Handclasp, as well as others. Over 1,400 pounds of such samples have been so disposed of during the past year.

PHYSICIAN — PHARMACIST CODE OF COOPERATION

The Faculty, together with the Maryland Pharmaceutical Assn., is developing a joint Code of Cooperation for the two professional groups.

Interested persons and those who have suggestions for incorporation in this Code should let the Faculty office know.

REFERENCE COMMITTEE MEETING

The Reference Committee is scheduled to meet on

Wednesday, August 23, at 8:00 p.m.

in the Faculty building.

CANCER RESEARCH

National Cancer Institute has established a Cancer Research Center at the USPHS Hospital in Baltimore, as a cooperative program in therapy and research. Of particular interest for study and treatment are patients with leukemia, malignant lymphomas and a few other malignancies. The purpose of the program is to evaluate conventional and newer approaches to therapy.

Interested physicians may write or telephone:

Arthur Serpick, M.D., Medical Service,
Baltimore Cancer Research Center
USPHS Hospital, Wyman Park Drive,
Baltimore, Md. 21211 Phone: 889-4429

John Sargeant

Executive Secretary

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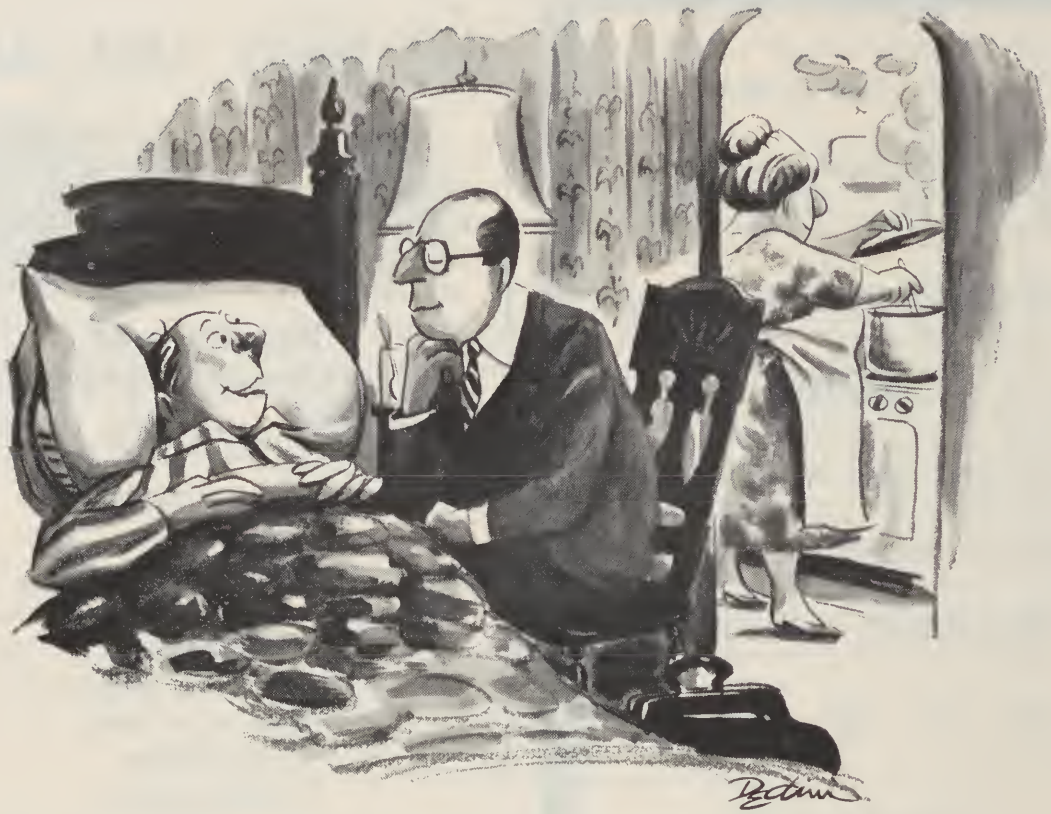


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JOHN SARGEANT — EXECUTIVE SECRETARY

ON MAY 11, THE EXECUTIVE COMMITTEE,

Took the following actions:

1. Authorized the use of the Faculty's mailing list for a solicitation letter in connection with Project HOPE.

2. Named a representative of the Faculty to act as liaison with the Appalachia Regional Medical Program. Chosen was Benedict Skitarelic, MD, of Cumberland.

3. Suggested the name of A. Murray Fisher, MD, Baltimore, to the State Board of Health and Mental Hygiene as a nominee for the list to be submitted by that group to the Governor for possible appointment to the Advisory Council on Air Pollution.

4. Selected Paul F. Richardson, MD, Baltimore, for the Governor's Award for Employment of the Physically Handicapped.

5. Rereferred to the MEDS Committee the question of a study to probe the possibility of (a) selecting specific hospitals for handling special medical and surgical emergency problems (b) evaluation from remote parts of Maryland and (c) discussing with the US Armed Forces the use of their transportation facilities, including helicopters.

6. Considered requests for provision of legal defense, even though dues had been paid after January 31 of 1967; and expressed concern over the number of such requests with a recommendation to the Council that in 1968 and subsequent years the Bylaws be interpreted more strictly on this point.

7. Recommended Donald Drinkard, MD, Baltimore, for appointment to the Baltimore Criminal Justice Commission as a Faculty representative.

8. Authorized Stuart Christhilf, MD, Annapolis, to discuss further the question of the Upton Scott, MD, House in Annapolis which is now for sale; and to contact Historical Annapolis Inc., in connection with its possible purchase. It is to be understood that this is not a commitment on the part of the Faculty.

9. Authorized expenditure of up to $150.00 for travel for the Public Relations Committee chairman to attend the annual AMA PR Institute in Chicago, in August.

10. Authorized an expenditure of up to $300.00 for a Seminar on the Medical Aspects of Sports to be sponsored by the Faculty and the Catonsville Community College. The College is providing $200.00, the program printing and the facilities for the seminar which is to be statewide.

11. Heard a briefing on the Title 19 program and the activities of the Fee Schedule Committee in this regard, and adopted a motion of "commendation" to this Committee for its activity and ardor in pursuit of solutions to the problems involved in this program.

12. Adopted "Emergency Procedures for Maryland Schools," at the request of the State Health Department.

13. Referred to the Council a proposed joint statement on The Role of the Registered Nurse in the Care of the Patient with Cardiovascular Disease, with the recommendation that it be adopted.


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From Washington

The American Medical Association proposed that Congress set up a National Commission on Health Resources and Medical Manpower with broad powers to supervise the drafting of physicians for military service.

The AMA recommendation was presented by Albert H. Schwichtenberg, MD, chairman of the AMA Council on National Security, at a Senate Armed Services Committee hearing on S. 1432 which would provide for a four-year extension of the present draft law expiring June 30.

Other AMA recommendations for modification of the doctor draft program included:

Expansion of the physician draft pool to include women doctors.

Making subject to draft call foreign physicians under 35 years of age, with permanent visas or who have subsequently become citizens, and who may not be subject to call because they were not deferred from induction while under age 26.

Limiting credit for fulfillment of the draft obligation to only service performed in the armed services. (Under the old law, service in the Public Health Service could satisfy a physician's obligation for active military duty).

Routine transfer, upon completion of an internship, of the jurisdiction of physicians to the local draft board serving the area in which the physician is engaged in training or practice.

Changes in the pay and promotion policies for military physicians designed to increase the retention of career military physicians.

"Our primary recommendation . . . is the creation of a National Commission on Health Resources and Medical Manpower," Dr. Schwichtenberg said. "This Commission would replace and be responsible for the functions of the present National Advisory Committee and the Health Resources Advisory Committee. This new Commission, under the direction of the President, would have the responsibility of maintaining a proper balance of health personnel, within existing resources, among the Armed Forces, other Government agencies, and the civilian population. Requests of the Secretary of Defense for health manpower in the military would be reviewed and approved by the Commission. The Commission would establish for the Selective Service System criteria for classifying, reclassifying and determining the order of selection for health personnel. Under this proposal, the present State Advisory Committees would be redesignated as State Health Manpower Committees, whose activities would be coordinated by the National Commission. It is further recommended that the Commission should be constituted from among persons of outstanding national reputation in the health-care fields, and its composition should include substantial representation from physicians in private practice."

A monthly summary of Washington News prepared in the Washington, DC, office of the American Medical Association.

The National Highway Agency's Tentative Standards on Emergency Medical Services

The National Highway Agency announced tentative standards for emergency medical services provided for persons injured in traffic accidents.

The Federal Standards give the states broad authority in implementation and also are subject to comment by the states before they become final. The State programs must be in full operation before Jan. 1, 1969, or a state could lose up to 10 percent of its allotted federal highway construction funds.

Although the Federal Standards apply only to traffic accidents, they are expected to necessarily set a pattern for emergency medical services generally.

William Haddon, Jr. MD, head of the National Highway Safety Agency, said the emergency care regulations are designed to provide quick response to accidents, sustain and prolong life through

proper first aid measures, reduce the likelihood of permanent disability and prolonged hospitalization, and provide speedy transportation of accident victims to hospitals.

The Federal Standards would require states to:

Appoint a full-time medical emergency services coordinator to have primary responsibility for the program.

Prepare a comprehensive plan for emergency services throughout the state.

Establish training, licensing and related requirements for ambulance drivers, attendants, and dispatchers.

Coordinate ambulance and other emergency medical care systems, including requiring ambulances to carry two-way radios hooked up with the police and hospitals.

Provide first aid training and refresher courses for emergency service personnel and policemen and firemen, and encourage first aid instruction for the public.

Other draft regulations with medical aspects:

Make physical and eyesight examinations for driver licensing.

Do compulsory blood tests for alcohol on drivers in accidents.

Reconsider Length of Stay for Foreign Medical School Graduates

John C. Nunemaker, MD, chairman of the American Medical Association's Department of Graduate Medical Education, told a House Judiciary Subcommittee that the AMA's position continues to be that graduates of foreign medical schools who come to the United States for training "should be encouraged in every possible way to return to their home countries where their skills are so badly needed."

Dr. Nunemaker suggested that the five-year length of stay provision for physicians on exchange programs be reconsidered. Every year beyond two or three years "intensifies the desire of the visitor to stay longer," he noted.

* * * * *

Two new studies in clinical pharmacology have been undertaken at Public Health Service hospitals, according to John J. Walsh, MD, Director, Division of Direct Health Services.

The studies are being carried out at the Public Health Service hospitals in Baltimore, Maryland,



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and San Francisco, California, two of 10 general hospitals operated by the Division. The studies are jointly sponsored by the Divisions of Direct Health Services and Medical Care Administration, both in the Bureau of Health Services.

The Baltimore hospital study, for which James R. Warbasse, MD, a cardiologist, serves as principal investigator, will seek to provide information on the efficacy of various quinidine preparations in the control of cardiac arrythmias.

The subjects of the study will be monitored by a portable electrocardiographic machine for periods of eight to 10 hours while they are engaged in their normal occupations at work and at home. Recordings will be repetitive, with patients on no dosage, a placebo, and quinidine preparations of identical strength but differing manufacture. Each subject will thus serve as his own control. The study began this month and will continue for at least a year. Subjects will be drawn from among Public Health Service hospital patients and from patients referred by community hospitals and private physicians in the area.

It has a number of objectives. The primary objectives are to study the physiologic availability of certain prefabricated medications and to study physiologic availability of certain drugs that are marketed in prolonged action formulations.

A consequent objective will arise if significant variations of such availability are encountered. In that event, the study will attempt to lay the groundwork for the development of physiologic availability standards, which do not now exist.

AAMA ANNOUNCES MEDICAL ASSISTANT SCHOLARSHIPS

Loans for medical assistant training are now available from the Maxine Williamse Scholarship Fund, sponsored by the American Association of Medical Assistants. Each loan is for $300. As AAMA assumes all administrat ive costs, there

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From Oklahoma

National authorities in the field of sports medicine will be lecturers at a special postgraduate course of the American Academy of Orthopaedic Surgeons.

Invited to attend the three-day course of lectures and audio-visual demonstrations are orthopaedic surgeons, general physicians, high school and college team physicians, and others with a medical interest in the care of the athlete. It is to be sponsored by the Academy's Committee on Sports Medicine in cooperation with the United States Olympic Medical and Training Services Committee and the Department of Orthopaedic and Fracture Surgery, University of Oklahoma School of Medicine, Oklahoma City.

Chairman of the course is Don H. O'Donoghue, MD, Chairman of the Orthodpaedic and Fracture Surgery Department at the medical school. The faculty is composed of distinguished lecturers from 14 states and Canada as well as members of the University staff.

Lecturers will discuss in depth topics including altitude and other medical problems related to the 1968 Summer Olympic Games in Mexico City, the adolescent athlete, competitive swimming, the anthropology and physiology of endurance runners, mechanics of running, the use and misuse of drugs in athletics, and effects of vigorous athletic activity on women.

A symposium on the arm in such throwing sports as baseball, javelin, shot putt, and discus will feature talks on shoulder joint and muscle injuries, elbow injuries and the aging pitcher. A special day-long forum will be devoted to diagnosis and treatment of knee injuries.

Members of the American Academy of Orthopaedic Surgeons' Committee on Sports Medicine speaking at the course will be its Chairman, Jack C. Hughston, MD, Columbus, Georgia; or-

thopaedic surgeon and orthopaedic consultant to Auburn University, Auburn, Alabama; Don H. O'Donoghue, MD, Fred L. Allman, Jr., MD, orthopaedic consultant, University of Georgia, and President-elect, American College of Sports Medicine; Martin E. Blazina, MD, Los Angeles, Assistant Professor of Surgery, UCLA; Bruce J. Brewer, Associate Clinical Professor of Orthopaedic Surgery, Marquette University School of Medicine, Milwaukee, Wisconsin; Joe W. King, MD, head, Division of Orthopaetic Surgery, Baylor University College of Medicine, Houston, Texas; Edmond J. McDonnell, MD, Associate Professor, Department of Orthopaedic Surgery, Johns Hopkins University School of Medicine, Baltimore; James A. Nicholas, MD, Assistant Professor of Clinical Surgery, Cornell University Medical College, New York; Fred C. Reynolds, MD, Professor, Orthopaedic Surgery, Washington University School of Medicine, St. Louis; and Donald B. Slocum, MD, Eugene, Oregon, orthopaedic surgeon and chairman of the A.M.A. Committee on the Medical Aspects of Sports.

For application forms and further information, physicians are asked to write to Dr. Don H. O'Donoghue, 1111 North Lee Street, Oklahoma City, Oklahoma 73103, or to the American Academy of Orthopaedic Surgeons, 29 East Madison Street, Chicago, Illinois 60602.

FAMOUS BRITISH PHYSICIAN TO RECEIVE AWARD

Cicely D. Williams, MD, FRCP, London, is to be the 1967 recipient of the Joseph Goldberger Award in Clinical Nutrition. The Goldberger Award of $1,000 and a plaque is presented annually by the Council on Foods and Nutrition of the American Medical Association and the Nutrition Foundation, Inc., to a physician who has made significant contributions to the knowledge of nutrition. Reciepients are nominated by the Council and selected by the AMA Board of Trustees.

Dr. Williams will receive the award June 21 at the Scientific Awards Dinner to be held during the American Medical Association's Annual Convention in Atlantic City, NJ.

Perhaps more than any other person in the world, Dr. Williams is responsible for improvement of child and maternal health in developing nations. Her investigations in Africa during the

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A general practitioner has a patient, a 17-year-old girl, who is planning to attend a year of school in Guatemala. She is a potential surgery patient. He is concerned about the type and quality of medical service available in the region. He writes to the Archive-Library for help.

You could be any one of these *AMA* members who benefit from the services of the *AMA* Archive-Library, just one dividend of your *AMA* membership. The Archive-Library services to members include conducting medical literature searches and compiling bibliographies free of charge. Another available aid of great value, the Library's photocopy service, is also free to you. Any article from any journal to which the Library has access can be copied and sent to you for your files.

The Library handles from 1,500 to 1,800 requests similar to those above for information and publications from physician members every month.

Questions and requests may range from the treatment of chlorine inhalation or statistics on human longevity to the latest treatment for Scleroderma or Raynaud's Disease to plans for the mass treatment of large numbers of burned patients.

The *AMA* Archive-Library upholds the traditional role of the medical library as an adjunct to the postgraduate education of the physician in practice, but it is even more than a library. It is a complete information center.

As a national medical society library, the Archive-Library is able to provide services not normally available on the local level. A more complete collection of materials allows the Library to supplement local library service. In addition, several special subject collections cover thoroughly such topics as international health, history and the sociology and economics of medicine. The *AMA*'s collection on the sociology and economics of medicine is the best in the world. It contains almost all the English language publications and includes opinions reflected in mass media as well as in scholarly works.

At the core of the Library is a collection of current medical publications. Today, 2,200 journals are received on a regular basis. This is twice the number contained in any average medical school library. These represent all the major publications in medicine and the allied sciences. In addition to the periodicals, the Library contains 40,000 books. This makes the Archive-Library one of the most complete current medical libraries you will find any place.

Of course your needs and requests determine the Library's content. The quantity and type of periodicals and reference books contained in the Library are guided by your requirements and those of the *AMA* staff.

Perhaps the one thing above all others which sets the *AMA* medical Library apart and makes it a true information center is the availability to the Library staff of a unique resource unavailable at many other medical libraries—the professional staff members of the AMA's 20 scientific departments. "The professional staff is here and we can

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use them," Susan Crawford, director of the Archive-Library, says. "Few other libraries have this type of consultation available. When a doctor writes to us and wants medical opinion or judgment, his question is referred to a consultant on the *AMA* staff, or to one of many specialists in the country, through the Questions and Answers Department of *JAMA*."

Such referrals are made in numerous areas such as medical physics, cardiology, psychiatry and drug therapy. Physicians on the *AMA* staff evaluate information for you before it is ever delivered.

For example, a question on drugs which requires clinical and pharmacological judgment is routed to the *AMA*'s Department of Drugs. The staff in that department can research all available

material on the subject and isolate the exact information you need.

The 26 members of the Archive-Library staff will go to great lengths to give you the information you need, and they are fully qualified to do so. They are especially trained to communicate with physicians—they speak your language. Half of the staff have graduate degrees in various areas and many have two masters degrees, one in library science and another in a chosen field such as economics, history or the biological and social sciences.

If you are a history buff, one of the more interesting areas of the Library is the Archive Section which houses documents and artifacts on the history of American medicine and the *AMA*. If you are at all interested in the progress of organized medicine, in the *AMA* or in tracing your ancestry or doing other historical research, the Archives hold a wealth of information for you.

The Library is always improving and enlarging its facilities. The last addition to the services was the International Health Section which has made it possible for all of the Library services to follow you, as a member of the *AMA*, wherever you go, whether it be the remote mountain stretches of West Pakistan, the rain forests of Brazil or a center of civilization such as Paris.

If you are planning an overseas trip or sabbatical, to set up practice or to attend a meeting or congress, the Library can give you all the information you need on foreign medical organizations, hospital and medical facilities in various countries, living conditions, what you should bring and the locations of the nearest American physician in any country.

The staff can also furnish you with information on a comprehensive and up-to-date listing of medical meetings outside the United States. After you are situated abroad the Library will continue to provide you with research facilities and photocopy services on specific medical subjects just as they did when you were stateside.

Any of the services of the Archive-Library are available to you by mail.

Copies of a "Guide to Services of the Archive-Library Department," a 16-page pamphlet, will soon be available through the *AMA* for your further information on this *AMA* service.

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Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

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whose anxiety follows such a patte



The psychosomatic patient.

ıe family physician is rarely given e diagnostic luxury of a classic, xtbook "anxiety state." Most often must probe for anxiety masked by functional disorder—or which exacbates a somatic problem. Doubleind evaluations have demonstrated at Mellaril can be a significant adnct in the treatment of such patients.



. The patient under ituational stress.

Iellaril helps the patient deal with :resses of everyday life. Nonhabituting, it can be given for extended peiods of time. It does not "separate" ıe patient from practical problems nd pressures, does not induce euphoia or a fuzziness which can compromise the ability to cope with realities. Rather, it helps the patient move more competently in his daily world by eliminating useless tension, by allowing him to conserve emotional resources and energies, and to direct them against the problems really worth worrying about.



4. The menopausal patient.

The woman who sees change of life as the end of useful life requires support from both family and family physician. Whether the psychological impact of menopause is directly related to hormonal changes, or merely coincidental, is debatable, but estrogenic therapy is frequently inadequate. Mellaril is a useful aid for these patients and, alone, or in combination with reduced estrogen dosage, will help ease the menopausal misery.



5. The previously hospitalized psychiatric patient.

Such a patient may still require the type of medication he has been accustomed to, but because he is no longer in a controlled setting the acceptable level of adverse reactions must be lower. In such circumstances Mellaril is perhaps the drug of choice.



6. The agitated geriatric.

Tranquilizer therapy in the elderly patient always involves special (or at least accentuated) problems: the possibility of drug-induced ataxia, hypotension or depression, for example, assumes an additional significance. These reactions have rarely been observed in geriatric patients treated with Mellaril.



7. The constantly returning patient.

The anxiety patient who has not responded to a minor tranquilizer is not very likely to benefit from your minor tranquilizer of second choice. A major tranquilizer, such as Mellaril, may be indicated in such patients.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.
Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.
Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.
Before prescribing, see package insert for full product information.

in moderate to severe anxiety, 25 mg. t.i.d.

Mellaril®
(thioridazine)

SANDOZ


Bartholin's gland
Periurethral glands
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Flagyl®
brand of
metronidazole
Seminal vesicles
Bladder
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Flagyl seeks out the sites where trichomonads hide. Only a systemic agent can. Flagyl does, selectively and effectively.

Flagyl destroys trichomonads in the inner crypts, glands and cavities of the genitourinary tract in both women and men. Consequently, Flagyl is capable not only of curing trichomoniasis in women but also of preventing reinfection.

Correctly used, with due attention to repeat courses of treatment for resistant, deep-seated invasion and to the presumption of reinfection from male consorts, Flagyl has repeatedly produced up to 100 per cent cure in large series of patients.

When the diagnosis of trichomoniasis is positive, Flagyl is positive.

Dosage and Administration — In *women:* one 250-mg. oral tablet three times daily for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.
In *men* in whom trichomonads have been demonstrated: one 250-mg. oral tablet twice daily for ten days.

Contraindications — Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precaution—Complete blood cell counts should be made before, during and after therapy, especially if a second course is necessary.

Side Effects—Infrequent and minor side effects include nausea, metallic taste, furry tongue and headache. Other effects, all reported in an incidence of less than 1 per cent, are diarrhea, dizziness, vaginal dryness and burning, dry mouth, rash, urticaria, gastritis, drowsiness, insomnia, pruritus, sore tongue, darkened urine, anorexia, vomiting, epigastric distress, dysuria, depression, vertigo, incoordination, ataxia, abdominal cramping, constipation, stomatitis, numbness of an extremity, joint pains, confusion, irritability, weakness, flushing, cystitis, pelvic pressure, dyspareunia, fever, polyuria, incontinence, decreased libido, nasal congestion, proctitis and pyuria. Elimination of trichomonads may aggravate candidiasis.

SEARLE *Research in the Service of Medicine*

Did Dorothy Larson show you her ankles in private? Now she shows them in public.

Your office examination would have confirmed that Mrs. Larson was up to her knees in edema. Her heart was beginning to fail. And her ankles had disappeared under an inch of salty water.

Along with digitalis, you might have prescribed Hygroton. To get rid of the edema. And to keep it from coming back. And you prescribe Hygroton the same way you usually prescribe digitalis: just once a day.

Tablet for tablet, Hygroton is just about the most effective diuretic going. And it costs a fraction of what Mrs. Larson would have to spend for equivalent therapy with short-acting diuretics.

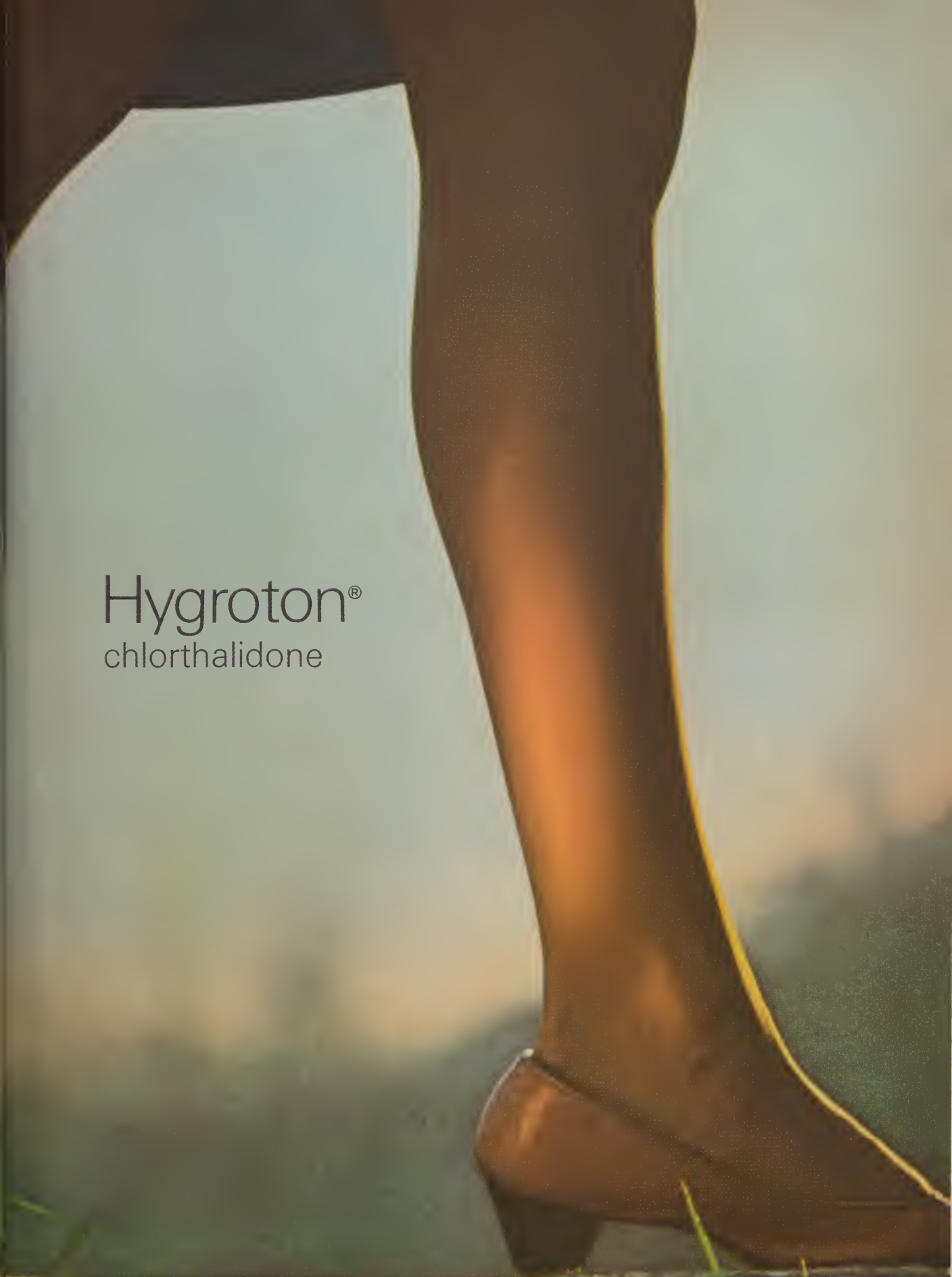
In fact, Hygroton is an awfully nice way to treat the Mrs. Larsons in your practice. Just tell them you can get their ankles back at half price.



Indications: Hypertension and many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.

Warning: With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.
Precautions: Reduce dosage of concomitant antihyper-

tensive agents by at least one-half. Discont
BUN rises or liver dysfunction is aggravated
imbalance and potassium depletion may oc
special care in cirrhosis or severe ischemic



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chlorthalidone

...tients receiving corticosteroids, ACTH, or digi-
Salt restriction is not recommended.
Effects: Dizziness, weakness, nausea, vomiting,
...glycemia, hyperuricemia, headache, muscle cramps,
postural hypotension, constipation, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin reactions, including urticaria and purpura, epigastric pain, or G.I. symptoms after prolonged administration.

Average Dosage: One tablet (100 mg.) with breakfast daily or every other day.
Availability: Tablets of 100 mg. 6524-V(B)
For full details, see prescribing information.

. . .so you might say Hygroton is good public relations for Mrs. Larson

Because it gets her *out* in public in the first place. At 43, Mrs. Larson worries about appearances and swollen ankles don't help.

But Hygroton's cosmetic effect is only half the story. Hygroton and digitalis therapy helps her get back in the swing of things. Gives her a second wind. Gets rid of the extra pillow she needed for a good night's sleep. Now she even likes to take walks. Just for the fun of it!

When her troubles began, Mrs. Larson thought they were the signs of the change of life. It's a change all right, but one you can treat. And you can count on Hygroton to help keep her in public instead of in the hospital.

See preceding pages for brief summary of prescribing information.

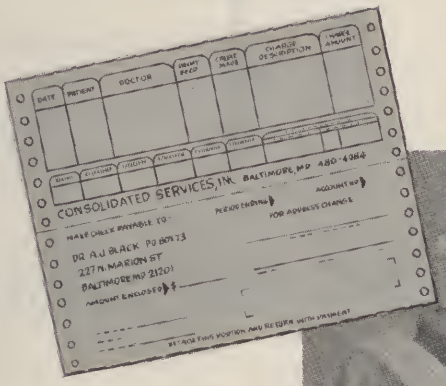


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Maryland State Medical Journal
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THE OUTPATIENT EXPLOSION

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Hospital Council of Maryland, Inc.

Everyone knows it is happening but few know the extent to which the use of outpatient clinics and emergency rooms has increased in recent years. This article will describe what has happened in Maryland hospitals in the last several years and will suggest possible projections to 1970. It will also inquire into some of the causes for this tremendous increase.

As stated by Rudolf J. Pendall, executive director of the Hospital Council of Maryland, in a discussion of the situation in outpatient departments, "There is a paucity of everything except patients." The number of patients has increased rapidly in recent years, often beyond the capacity of hospitals to handle them adequately. Reimbursement has been inadequate, often below costs, although this is improving. The quality of care has been spotty, and too often the vertical patient has been considered a second-rate patient. This is not intended as an indictment of outpatient departments; frequently they have performed major or minor miracles, and usually they have offered dedicated service to mankind under very trying circumstances.

THE SITUATION IN MARYLAND

A list of hospitals having an emergency room and/or organized outpatient clinics is presented in Table 1. The Baltimore metropolitan area appears to be adequately supplied, with 17 emergency rooms and 18 hospitals having a variety of organized outpatient clinics. Eleven of these hospitals are planning to expand their outpatient departments. In the remainder of the State, outside of the Baltimore metropolitan area, there are 25 general hospitals all with emergency rooms. Seven of these general hospitals plus the Veterans Administration Hospital at Perry Point have organized outpatient clinics. Twelve expect to expand their outpatient departments. In this survey, no attempt was made to gauge the quality of care in the emergency rooms, but it seems obvious that in the smaller hospitals where the emergency rooms are staffed by physicians on call, the quality and immediacy of treatment in an emergency are not always of the same quality that might be expected in a hospital where there is full-time medical staff coverage.

The increase in outpatient and emergency room visits across the nation is now too well-known to be called a phenomenon. The national picture is portrayed this Table 2, which shows the number of outpatient and emergency room visits in short-term hospitals throughout the United States for the four years beginning with 1962. A similar picture is shown for Maryland in Table 3, in which the outpatient visits to Baltimore hospitals

Table 1
HOSPITALS IN MARYLAND HAVING EMERGENCY ROOM AND/OR ORGANIZED OUTPATIENT CLINICS

BALTIMORE METROPOLITAN AREA	With Emergency Room	Number of Organized Clinics	Plans to Expand OPD
Baltimore City Hospitals	x	48	x
Baltimore County General Hospital, Inc.	x	1	
Bon Secours Hospital	x	7	x
Church Home and Hospital	x	14	
Franklin Square Hospital	x	6	
Greater Baltimore Medical Center		21	
The Johns Hopkins Hospital	x	107	x
Lutheran Hospital of Maryland	x	25	
Maryland General Hospital	x	17	x
Mercy Hospital, Inc.	x	31	x
Provident Hospital	x	18	x
St. Agnes Hospital	x	14	x
St. Joseph Hospital	x	23	
Sinai Hospital of Baltimore, Inc.	x	79	x
South Baltimore General Hospital	x	15	
The Union Memorial Hospital	x	21	x
University Hospital	x	47	x
US Public Health Service Hospital	x	19	x
TOTAL BALTIMORE	17		11
OUTSIDE OF BALTIMORE METROPOLITAN AREA			
The Anne Arundel General Hospital	x	0	x
Calvert County Hospital	x	0	
Cambridge-Maryland Hospital, Inc.	x	4	x
Carroll County General Hospital	x	0	
The Memorial Hospital (Cumberland)	x	0	
The Memorial Hospital at Easton, Md, Inc.	x	5	x
Frederick Memorial Hospital, Inc.	x	0	
Garrett County Memorial Hospital	x	0	x
Harford Memorial Hospital	x	0	x
Holy Cross Hospital of Silver Spring	x	5	x
Kent & Queen Anne's Hospital, Inc.	x	0	
Laurel General Hospital	x	0	
Eugene Leland Memorial Hospital (Riverdale)	x	0	
The Edward W. McCready Memorial Hospital (Crisfield)	x	0	
The Miners Hospital Corporation (Frostburg)	x	0	
Montgomery General Hospital, Inc. (Olney)	x	0	x
Peninsula General Hospital (Salisbury)	x	2	x
Physicians Memorial Hospital (LaPlata)	x	0	
Prince George's General Hospital	x	21	x
Sacred Heart Hospital (Cumberland)	x	0	
St. Mary's Hospital (Leonardtown)	x	0	
Suburban Hospital Association (Bethesda)	x	13	x
Union Hospital of Cecil County	x	0	
Washington County Hospital	x	0	x
Washington Sanitarium and Hospital (Takoma Park)	x	5	x
VA Hospital, Perry Point		25	
TOTAL, NON-BALTIMORE	25		12
TOTAL, MARYLAND	42		23

and to non-Baltimore hospitals are shown for 1960 and 1965, and estimated for 1970. Also shown in the Table are the number of inpatient days for the same years in the same group of hospitals. It must be understood that inpatient days are not strictly comparable with out-patient visits, but presenting both sets of data does permit a comparison of trends. Figure 1 and 2 show the increase in outpatient visits to Baltimore hospitals in a more graphic manner. Figures 3 and 4 present the same type of information for hospitals outside of the Baltimore metropolitan area.

The increase in outpatient visits in the last 10 to 15 years is shown for a few selected hospitals in Baltimore in Table 4. The selection of these hospitals was made for the pragmatic reason that the data were available. It should be noted here that in most of the tables presented, the outpatient clinical visits have been combined with the emergency room visits. This has been done because the

Table 2
OUTPATIENT AND EMERGENCY ROOM VISITS IN U S SHORT-TERM GENERAL HOSPITALS AND OTHER SPECIAL HOSPITALS *

Year	Number of Visits
1962	70,727,474
1963	85,764,089
1964	91,429,548
1965	92,631,497

* "Hospitals, JAHA," Guide Issue: 1963, 1964, 1965, 1966.

data are not entirely reliable when separated. In many instances a patient comes to an emergency room and is recorded as a visit, but is actually sent to an outpatient clinic. The practices vary enough from hospital to hospital to render these data not completely comparable. The total outpatient visits are considered reliable, however.

Why The Explosion?

With the situation in Maryland hospitals clarified, it becomes necessary to look at the "why." Someone is reported to have asked the notorious Willie Sutton why he robbed banks. He replied, "Because that's where the money is." This seems to have some application to the outpatient problem

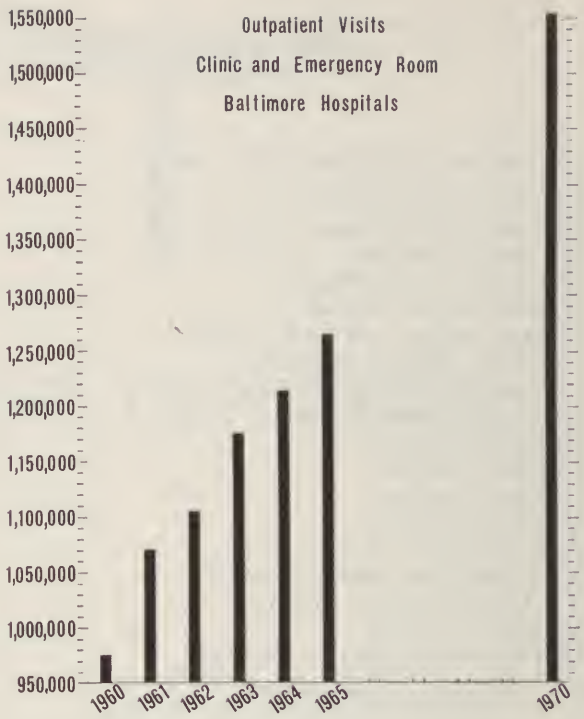


Fig 1
Outpatient Visits: Clinic and Emergency Room, Baltimore Hospitals

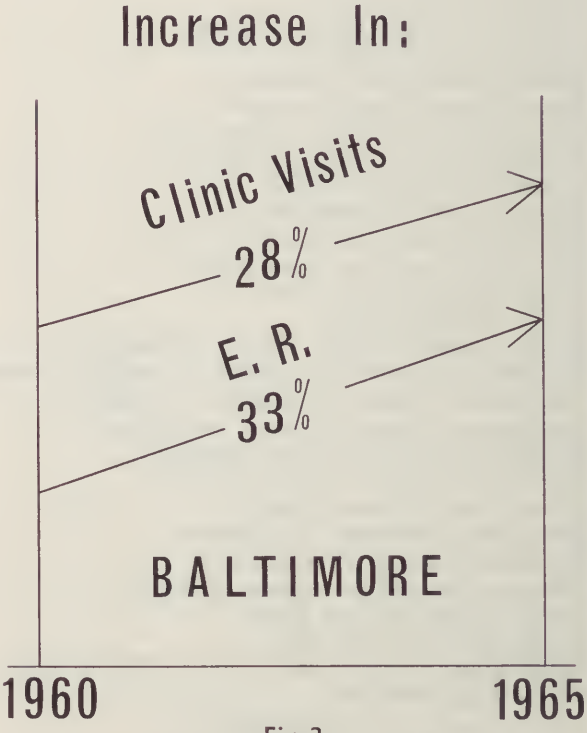


Fig 2
Increase in Clinic and Emergency Room Visits, 1960-1965, Baltimore Hospitals

Table 3
UTILIZATION OF GENERAL HOSPITALS IN MARYLAND

Outpatient Visits
(Organized Clinic and Emergency Room)

	1960 *	1965 †	Estimated 1970	Estimated Percentage Increase 1960-1970
Baltimore Hospitals	975,355	1,264,033	1,555,000	59%
Non-Baltimore Hospitals	132,831	243,014	420,000	216%
STATE	1,108,186	1,507,047	1,975,000	78%
		Inpatient Days		
Baltimore Hospitals	1,612,280	1,716,018	2,207,836 ‡	37%
Non-Baltimore Hospitals	748,324	1,005,867	1,206,222 ‡	61%
STATE	2,360,604	2,721,885	3,414,058 ‡	45%

* "Selected Hospital Statistics—Annual Report, 1960," Hospital Council of Maryland, Inc.
† "Selected Hospital Statistics—Annual Report, 1965," Hospital Council of Maryland, Inc.
‡ "Planning, Research Bulletin No. 5," September 1965, Hospital Council of Maryland, Inc.

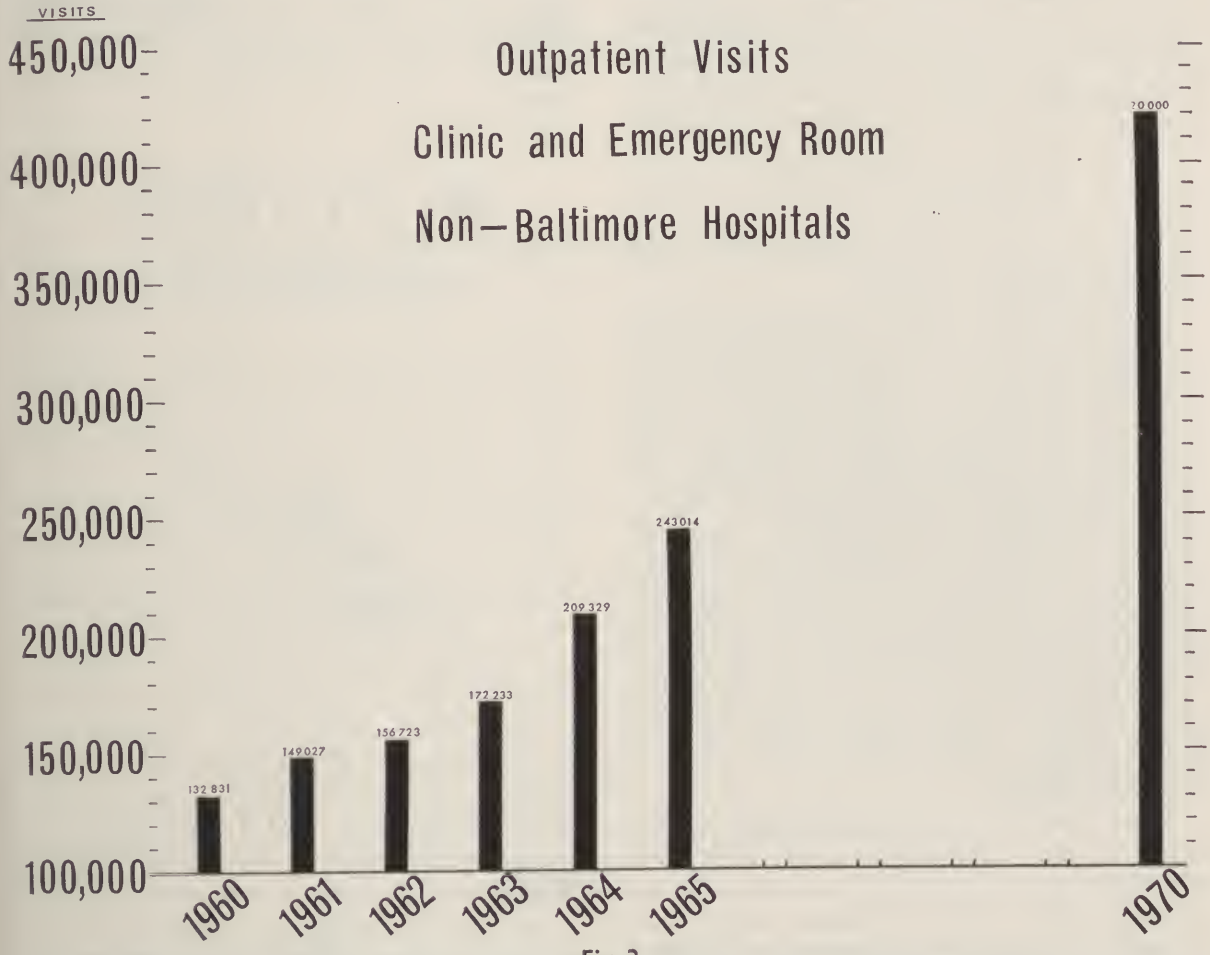


Fig 3
Outpatient Visits: Clinic and Emergency Room, Non-Baltimore Hospitals

in hospitals. People go where the medical services are.

Studies have been made to determine the cause of the outpatient explosion. To some extent, these studies merely state the obvious. The doctors themselves are one major reason why more and more people are going to outpatient clinics. In fact, many patients are referred by the physician. Physicians are unwilling to make home visits, and instead they refer patients to a hospital. There is also the undeniable fact that the outpatient department of the community hospital has much more equipment than the physician can have in his own office. The decrease in the actual number of general practitioners in most cities is another factor.

A survey of outpatient department usage was made in 22 hospitals in Michigan in 1965.[1] The researchers found that 46% of the patients who went to an outpatient department in a given period of time had first phoned a physician. Of this group, 35% had been instructed by the physician to go to the hospital or to meet him at the hospital. Traumatic injuries accounted for 57% of all the persons who went to an emergency room. Of the remaining non-traumatic cases certainly some could be considered emergencies. Of the traumatic cases, 34% tried to reach a physician before going to a hospital.

In the large urban areas, the increased mobility of the population has contributed to an increase in outpatient department usage. Large numbers of people in the economically disadvantaged areas of cities have no family physician, and people who have recently moved into a city, or who frequently move from place to place within a city, find it difficult to establish a relationship with a physician even if they so desire. For those patients with Blue Cross or other types of medical insurance, there is sometimes an incentive to obtain medical treatment at a hospital rather than in a physician's office because the third-party payer does not always include private physician office visits in the list of benefits.

What is an emergency? The lay person is apt to define a medical situation as an emergency when the doctor would not define it as such. To the person suffering from a sprained ankle, or a toothache, or a migraine headache, the situation may very well be an emergency, but the doctor in the emergency room will not so define his condition. On the telephone, the determination of what is an emergency becomes even more difficult. The person who phones his physician and complains of a pain in his chest may have indigestion or may be suffering from a coronary attack, and the safest procedure for the doctor is to tell the patient to go to the emergency room of the nearest hospital.

The outpatient department has been called the supermarket of modern medicine. It provides a variety of types of care to large numbers of patients. It is often impersonal, and has been referred to as casual medicine. It is, in contrast to the private "appointment and referral" type of medicine, practiced by many modern physicians.

What Of The Future?

Where are we going in our outpatient departments? There seems to be no doubt that more medical care will be given at the hospital. The charts in Figures 1 and 2 attempted to project the

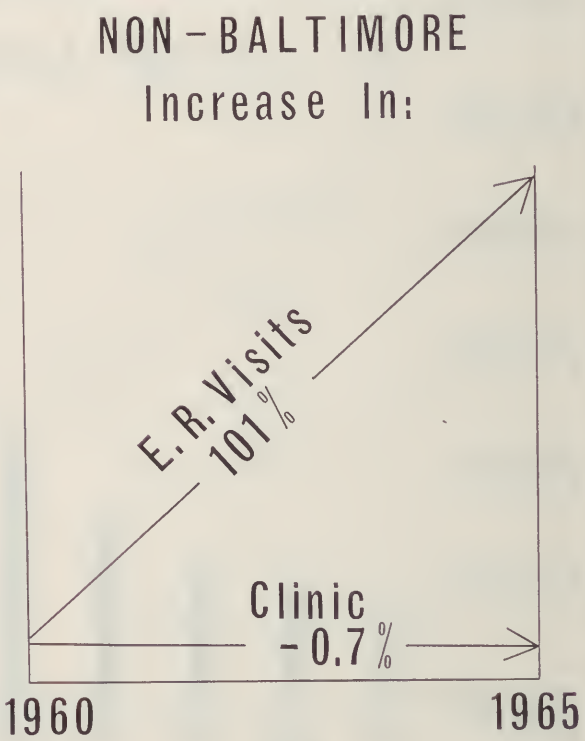


Fig 4
Increase in Clinic and Emergency Room Visits 1960-1965, Non-Baltimore Hospitals

Table 4

OUTPATIENT VISITS (INCLUDING EMERGENCY ROOM) TO SELECTED BALTIMORE HOSPITALS

Hospital	Year	Visits	Percent Increase in Last 10 Years
Baltimore City Hospitals	1952	59,347	
	1955	77,257	
	1960	86,515	
	1965	141,361	83.0%
Mercy Hospital, Inc.	1950	25,502	
	1955	29,097	
	1960	46,168	
	1965	49,404	69.8%
The Union Memorial Hospital	1946	21,143	
	1951	25,157	
	1956	38,042	
	1961	54,039	
	1966	66,601	75.1%
University Hospital	1950	128,764	
	1955	153,478	
	1960	177,005	
	1965	195,512	27.4%

number of outpatient visits in 1970 in Baltimore and non-Baltimore hospitals. The slope of the curve may be questioned but all indications seem to point to continued and possibly greater increases in utilization of outpatient facilities, including emergency rooms. There have been hospitals around the nation that have atempted to stem the tide by publicity in the newspapers and by brochures explaining the proper use of emergency rooms and outpatient departments. These attempts have been almost completely unsuccessful. The person who has what he considers an emergency condition is not going to heed the suggestion that he should seek medical treatment from his own physician first if the hospital is more convenient.

Doctors have divided opinions on this situation. There are those who think the emergency room should be used strictly for emergencies and that most of the remainder of medical practice should be performed in the doctors' offices. On the other hand, there are those who think that the hospitals are not performing the service they should be performing and that the outpatient departments should play a major role in the medical care of our people. The vertical patient, they say, should be considered as even more important than the horizontal patient: the better and more complete the treatment given to the vertical patient, the fewer horizontal patients there will be in hospital beds. The doctor's office, in or next door to the hospital, seems to make eminent good sense.

This article was not intended as promotion for a cause. It was presented to summarize what is happening in Maryland hospitals. We can only conclude, however, that the center of medical attention for most of the population is becoming the hospital. It seems apparent that more and more medical complexes will consist of inpatient centers, outpatient departments including emergency rooms, and doctors' offices. Other ancillary services may well be added to the principal services. It can be said, with considerable assurance, that this trend will continue.

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MEDICAL CARE: THE NEXT DECADE IN THE PUBLIC-PRIVATE PARTNERSHIP

PHILIP R. LEE, MD
Assistant Secretary for Health and Scientific Affairs
US Department of Health, Education, and Welfare

Medical practice has changed greatly. Yet the judgment is widely expressed, in and out of medicine, that the changes have not been profound enough to keep pace with the growth of medical knowledge and the rise of society's expectations and demands. The current problems of medicine are in large measure problems created by its own success.

It is a pleasure to meet with you to discuss a subject that I believe is of mutual interest—the next decade in the public-private partnership in medicine.

In order to view the present and future relationships in context I think it is essential that we be aware of the many forces at work in our society which have an important influence on medicine.

The recent report of the Citizens Commission on Graduate Medical Education, commissioned by the American Medical Association, provides much food for thought on this subject. I would like to quote from the Introduction of the Report:

> Medical education and the practice for which it gives preparation face problems quite different in kind but nearly as profound as those which concerned Abraham Flexner half a century ago. When Flexner wrote, medical education and practice were suffering from the lack of a solid, scientific base. Now, the scientific base not only exists but has grown so explosively that it has outrun much of medical practice. Then, medical education suffered from the lack of effective standards. A problem of today is the complexity, the fragmentation, and the inflexibility of standards for graduate medical education. When Flexner conducted his inquiry into medical education, the public was little concerned. Now the public is deeply concerned.
>
> The informed public knows of the revolutionary development in medical knowledge, of dramatic advances in surgical skill, and of new vaccines and "miracle" drugs. Knowing all this, society expresses its grateful appreciation by spending much more on medical services and by generously supporting research that is confidently expected to lead to still greater medical achievements.
>
> The informed public also knows, however, that a wide gap exists between the best that medicine can offer and the lesser services actually available to many patients.

In reviewing the major trends in medical education and practice the Commission highlighted the following trends as of particular significance:

1. Increasing knowledge and the resulting increase of specialization;
2. Rising expectations and demands for medical and health care;
3. The changing geographic distribution of the population; and
4. The increasing institutionalization of medical practice.

I would modify this list only slightly, emphasizing:

1. Sustained economic growth and a rising per capita income;
2. Increasing expenditures for health and medicine, both in absolute terms and as a percentage of gross national product or disposable income;
3. The growth of private health insurance;
4. Federal support of biomedical research, health manpower development and health facilities construction; and
5. Federal programs to reduce or eliminate financial barriers to medical care.

It is against this backdrop of change that I

Delivered at the 169th Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, The Alcazar, Baltimore, April 20, 1967.

shall discuss the public-private partnerships that have developed in the past 30 years. I will emphasize the role of the federal government and the private sector, because it is this relationship that is exerting the major influence today.

The federal government's role in medical care actually pre-dates the Constitution. The US Army medical services trace their origin to the Revolutionary War. The United States Public Health Service, our major domestic health agency, had its origins in 1798 with the organization of medical care services for merchant seamen. The Civil War saw an expansion of medical care programs for veterans, and it was during this period that Saint Elizabeths Hospital, a federal mental hospital, opened its doors.

The present role of the federal government in domestic health programs did not really begin to take shape until 1935, with the passage of the Social Security Act. The Social Security Act, in addition to establishing the Old Age Survivors and Disability Insurance program, established federal grants to the states for maternal and child health services, crippled children's services, public health and public assistance programs. This pattern of federal-state grant-in-aid programs was followed for the next 30 years, with over 20 separate grants now in effect for the support of state and local public health programs.

The National Cancer Act, enacted in 1937, was perhaps the single most important health bill ever enacted by Congress. This law formed the basis of federal support for biomedical research in the United States, and it resulted in one of the most fruitful public-private partnerships now in existence. There is little question that the scientific and technological developments in medicine in the past 30 years are the single most important influence on medical education and medical services.

The National Cancer Act created a mechanism for the support of research by able investigators in non-federal institutions, and it also established an intramural program that was to grow and become the world famous National Institutes of Health. In these 30 years a strong partnership between the federal and non-federal institutions and scientists has been established.

The Public Health Service Act of 1944 extended the basic principles established in the National Cancer Act, and gave to the Surgeon General broad authority to support research related to health and disease.

The next step occurred in 1946 with the passage of the Hospital Survey and Construction (Hill-Burton) Act. In this legislation another unique public-private partnership was established. In this case federal funds were made available to state governments; these, in turn, made them available to non-profit, voluntary community hospitals, nursing homes and other health facilities. The results are known and appreciated in the more than 3,000 communities in this country where new or remodeled health facilities exist because of the program. In the 20 years of the Hill-Burton program almost 350,000 hospital and nursing home beds have been constructed. Like our program of biomedical research, the primary result of this program has been to strengthen the private sector and the non-federal partnership in our vast health industry.

The period from 1946 to 1960 saw little fundamental change in the federal role in medicine, although there was significant and rapid growth in federal support for biomedical research and research training.

The Kerr-Mills law of 1960 established the principle that a person did not have to be on public assistance in order to receive aid for the payment of medical services. This was a federal-state program, which built on previous public assistance medical care programs and which became the base for the 1965 Social Security Amendments that established a single category of medical assistance.

The federal role in consumer protection assumed a new dimension in 1962 with the enactment of the Food and Drug Amendments that year. The law required that a drug manufacturer demonstrate not only the safety but also the efficacy of a new drug. Safety had long been a requirement, but it had never been necessary to prove efficacy prior to that time.

It was not until 1963 that the federal government was authorized to provide funds in direct support of medical education. Since that time, passage of the Nurse Training Act of 1964 and the Allied Health Professions Personnel Training Act of 1966 extended this support to all the health professions. The federal government also provides support for all other levels of health occupations training through the Vocational Education Act, the Manpower Development and Training

Act, and the Economic Opportunity Act.

The federal role in financing medical care was dramatically altered in 1965 with the enactment of the Social Security Amendments. Medicare established a program of hospital and medical insurance for all those aged 65 and over, as a matter of right. The Medical Assistance Program established a single category of medical assistance, rather than the multiple categories for the aged, the disabled, the blind and families with dependent children that had previously existed. This program was aimed at providing the poor with the same quality and scope of medical services available for the bulk of the population. Again, we find the federal programs strengthening those of state and local governments as well as the private sector.

Both program planning and the strengthening of state and local initiative received special emphasis in the Heart Disease, Cancer and Stroke Amendments of 1965 and the Partnership for Health Amendments of 1966. The Partnership for Health Amendments provide funds for the creation of a state health planning agency and an advisory council to bring together the various private and public groups involved in health and medicine today, in order that better judgments can be made on the development and utilization of resources.

The Heart Disease, Cancer and Stroke Amendments provided a mechanism for the development of regional medical programs to speed the flow of knowledge and improve the services at the patient's bedside. Again, this legislation recognized the importance of decentralization and of cooperation between the various elements in the private sector—private physicians, medical schools and university hospitals, non-profit and community hospitals, and voluntary agencies—with those of state and local government.

I have traced the development of the federal role in health and medicine as it has been evolving over the past 30 years, and as it has been reflected in laws enacted by the US Congress.

The pace has quickened in recent years, particularly since 1963. In the short period of four years, 24 major new health laws have been enacted, and a number of other laws in civil rights, traffic safety, education, housing and urban development, and other fields have been enacted that will have a profound impact on medical research, medical education and medical care.

The federal role in health and medicine is now expressed through six broad areas:

1. Programs designed to advance research in the cause, prevention, treatment or care of diseases, defects and disabilities;
2. Programs to meet the manpower, facility and other resource requirements of the health industry;
3. Programs designed to stimulate local, regional and state initiative and improve the effectiveness of federal, state and local government efforts in public health;
4. Programs designed to remove the financial barriers to health care;
5. Programs to improve the quality, availability and effectiveness of health services; and
6. Programs designed to protect the consumer, and to reduce the hazards in, and improve the quality of, our environment.

The effectiveness of each of these approaches needs to be carefully, objectively and critically assessed. The role of the federal government in each of these areas has been growing. In some cases the results have been brilliantly successful. In other areas the results have yet to be assessed. In each case, however, we must ask ourselves why have the people—through laws enacted by Congress—taken this course. The growth in federal support for these programs is a reflection of the magnitude and rate of change of the federal role in health and medicine.

Support for biomedical research has increased from $8 million to $800 million in the last 20 years. Federal support for biomedical research has been thoroughly examined and evaluated. The most recent study was that completed under the direction of former Supreme Court Justice Whittaker. Perhaps the most comprehensive analysis was that done a few years ago under Dean Wooldridge. The programs have also been scrutinized by various Congressional committees. In general, the programs have received high praise—praise, in my opinion, which is well deserved. There is little question that our present biomedical research effort is exerting a profound influence for change in our system of medical education and in our system of delivering medical services.

Support for the development of manpower and facilities will exceed $1.3 billion in fiscal year 1968, if Congress appropriates the funds that

have been requested. This represents a $500 million increase in federal expenditures for health manpower and facilities in the past three years.

The federal role in health manpower now covers support for the full spectrum of the health team, from the highly trained medical specialist to the home health aide or auxiliary health worker. All have essential roles to play in providing the services needed.

Federal support for construction of facilities has been provided primarily through the Hill-Burton program. This highly successful public-private partnership has been largely responsible for the revitalization of our hospital system since World War II. In the 20-year period from 1947 to 1967 during which this program has been in effect, federal funds have contributed to the construction of almost 350,000 hospital and nursing home beds.

In spite of great progress in hospital construction, we face major problems: the urban hospitals require major modernization and renovation; new beds must be built; new types of facilities, particularly for ambulatory services, are urgently needed.

In addition to the Hill-Burton program, there are federal programs supporting the construction of university medical centers, community mental health centers and mental retardation treatment facilities, mortgage guarantees for group practice facilities, and a number of other related programs.

Support for state and community programs covers a wide range of activities. The President has requested new authorizations in this area that would permit expenditures of $170 million in 1968, an increase of almost $60 million over funds now available through categorical grant-in-aid programs. This proposal, termed the "Partnership for Health," was enacted last year by Congress and a four-year renewal is being requested.

Regional medical programs, established by the Heart Disease, Cancer and Stroke amendments, are now in the planning stage in over thirty regions. Programs are expected to be in operation this spring in four of these areas. The program is now being reviewed by a group of outside advisors and this June the Surgeon General will submit a report to the President and the Congress on the program. The program has, I believe, great promise because it is helping to break down some of the artificial barriers that have tended to divide physicians in private practice from those in academic medicine. It is also bringing a number of interested parties, including consumers, into the process.

Programs designed to remove the financial barriers to health care now take the lion's share of federal funds in health and medicine. Payments for medical and hospital services in non-federal facilities have risen more rapidly than any other health related expenditure—from $1.3 billion in fiscal year 1966 to an estimated $6.2 billion in fiscal year 1968. Medicare is, of course, the primary reason for this rapid rise.

Programs designed to improve the quality and availability of medical care have increased rapidly in recent years. They include neighborhood health centers, maternal and infant care projects, migrant health services, and projects to provide comprehensive medical care for preschool and school age children in low income areas. Expenditures in these programs will approach $300 million in 1968, a three-fold increase in less than five years.

A very important development in this regard will be the establishment, this year, of the National Center for Health Service Research and Development. The Center will be concerned with the definition and solution of practical problems related to the quality, availability, organization, financing and delivery of health services.

The final area that I described as an important one for the federal government, namely, consumer protection and environmental health, is assuming increasing importance for all of us. Federal expenditures in the Department of Health, Education, and Welfare will total more than $200 million this year. In addition, there are important programs in the Departments of Interior, Agriculture, Transportation, and Housing and Urban Development. The federal role in air and water pollution control has assumed increasing importance in recent years, as has its role in traffic safety.

Where do we go from here? It seems highly probable that in the next ten years we will continue to build on the public-private partnerships that I have described.

I believe a number of significant advances will be made in biomedical research. We should have

the means at hand to eradicate rubella and perhaps much more effectively control a number of upper respiratory infections. There may be a major breakthrough in the better understanding of the relationships of viruses to leukemia. Your meeting today gave some indications of the possibilities in research related to arteriosclerosis and coronary thrombosis.

Computers will play an increasingly important role in medicine. The computer, combined with the development of improved automated laboratory techniques, should provide the physician with more and better data about his patients. The developments in multiphasic screening may make it possible for the physician to markedly expand his productivity in terms of early diagnosis and prevention.

Bioengineering will be extended to a number of areas where programs are now just beginning: the artificial heart and the artificial kidney; postoperative care, intensive care and surgical monitoring; the development of patient simulators and other technological innovations that can improve and extend training programs.

New hospitals will be built and many of our existing hospitals will be rebuilt or renovated in the next ten years.

It seems highly probable that there will be further extension of hospital and medical insurance or prepayment among gainfully employed persons, among the unemployed, the disabled, the indigent and the medically indigent. This will take place, I believe, through the further growth of voluntary insurance—which provided in December 1965 some protection for hospital, surgical and or medical costs to over 156 million people (81% of the population); through an extension of Medicare to the 1.5 million disabled who now receive Social Security benefits; and through the full implementation of the Federal-State Medical Assistance (Medicaid) Program.

It is very likely that within five to ten years there will be no "free" or "charity" patients in our hospitals: virtually everyone will have his hospital and medical costs met, as a whole or in part, by some third party.

In the next ten years we will see a major research and development program in health services. This program may well reach the dimensions of the present programs of biomedical research. It will focus on such problems as the rising costs of medical care; the effective and efficient use of personnel; the application of computers, automated laboratories and other technological advances; and the design and construction of hospitals, nursing homes, group practice facilities and other health care facilities.

Finally, I visualize a more vigorous and important role for county, district and state medical societies in the definition of local problems and in the development and carrying out of programs to solve the problems. We are already seeing this in programs of health education, health manpower development and health services for the poor.

In closing, I would like to not that it is an understatement to say that ours is a period of transition or change. Some have described it as a revolution—in rising expectations, in science and technology, in medicine.

Certainly, as we view these turbulent times in medicine, and as we view the changing role of the public-private partnerships that have evolved in the last 30 years, we would do well to bear in mind a statement by Alfred Whitehead, He said, "The art of progress is to preserve order amid change and to preserve change amid order."

Certainly we are saying goodbye to an older era. Certainly we are greeting a new one, and a better one. This new encounter is accompanied by difficulties, by problems, and by the demand for energetic and earnest effort. To this I believe we must all apply ourselves with dedication, and not necessarily in a spirit of martyrdon. I prefer the philosophy of the late Winston Churchill—the cheerful and devoted philosophy which he displayed to a group of temperance ladies when they called on him to protest his inordinate consumption of brandy.

"Why, Mr. Churchill," said one, "if all the liquor you consume in a year were poured into this room, it would fill it to here."

She pointed to a spot midway between the floor and the ceiling.

The Prime Minister gravely regarded the lady, the floor, the ceiling, and the spot she indicated.

"So little done," he murmured, "and so much to do."

THE FORGOTTEN PHILANTHROPIST

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Mount Wilson State Hospital is a tuberculosis hospital sitting on a hill two miles from Reisterstown Road in Baltimore County. The man for whom it was named, Thomas Wilson, was one of those merchant-philanthropists of the "stewardship" school to whom Baltimore owes much of its subsequent reputation as a cultural and medical center. Unlike George Peabody, Henry Walters, Johns Hopkins and Enoch Pratt, Mr. Wilson's name is shrouded in comparative obscurity. Indeed, there are few persons today who have even heard of him and there is very little recorded information about him; perhaps, because his estate benefited only the sick and the poor and not the ambitious. Although what we have uncovered is by no means complete, it is enough to show that Mr. Wilson was one of the great contributors to public health in Baltimore, a city that was for years, known for its lack of it.

He was born in Harford County in 1789, the son of John Wilson. The family moved to Baltimore in 1798. Although the Baltimore Society of Friends shows no record of the family before July 4, 1872, when Thomas Wilson joined the group by request, Mr. Wilson was apparently a Quaker all or most of his life. His father was listed as one and there are other references to Thomas Wilson's conduct being governed by Quaker beliefs.

When he was seventeen Wilson was apprenticed to a prominent Baltimore merchant, Thorndick Chase. He worked in Chase's counting rooms until shortly before his apprenticeship obligations



THOMAS WILSON

were fulfilled at age twenty-one. During those years with Chase he became chief clerk and was in charge of the company's books.

He left Chase in 1810 and with a Mr. Brown, who supplied the capital, founded the shipping firm of Brown and Wilson on Fells Point.

The next year Wilson went to the West Indies in a chartered ship to sell a cargo that was partly owned by his firm. The young firm made enough money from that venture to buy its own ship, the schooner, "Spencer." They concentrated on trade with the Venezuelan coastal city, La Guaira. However, their business was interrupted the next year when the War of 1812 began and they were forced to sell the schooner.

Shipping in Baltimore during that war was greatly hampered by the effective British naval blockade of the Chesapeake Bay. Privateering presented the only effective means of shipping goods from the city. Because of their Quaker beliefs, Brown and Wilson would not participate in privateering. Instead, Wilson organized a line of small ships that sailed between Boston and Folly Landing, Virginia, on the Atlantic Coast. There they were met by a string of small open boats that transported the goods between Folly Landing and Baltimore.

When the war ended, Brown and Wilson entered into an agreement with another Baltimore company to re-establish the Venezuelan trade. As part of the agreement Wilson was to live in Venezuela for at least a year to sell the cargos.

However, in the ensuing year, the situation had changed in Venezuela. With the overthrow of Napoleon in Europe, the Spanish were free to concentrate on re-establishing control of Venezuela after Simon Bolivar had severed it in 1811. When Wilson reached there in 1814 the country was caught up in the Spanish counter-revolution of 1814-15. Wilson was clapped in jail at one point for a brief time, when he protested the impounding and selling of the cargo from one of his ships by the city government in Puerto Cabello. Shortly after his release Wilson contracted yellow fever and was ill with that disease for several weeks. Those events and the internal dissension caused by the uncertain political situation that provided little security for his ships or cargos, caused Wilson to leave the country. He returned to Baltimore in 1816.

In 1819, Mr. Brown retired. Wilson found the company difficult to manage alone and took G. W. Peterkin as his partner, who remained in that capacity until his death in 1837.

Mr. Wilson's partners from 1837 until the depression of 1857 were W. S. Peterkin and R. W. Allen. During that depression the firm, then called Thomas Wilson and Company suffered heavy losses that Wilson covered with his personal assets.



A view of one of the original buildings of the Mount Wilson State Hospital. This building has, over the years been renovated and updated in its facilities.

Although that depression and the Civil War cost him heavily, Wilson managed to build another fortune of $2,000,000 between 1865, when he was seventy-six years old and the year of his death, 1879.

Besides his shipping activities, Wilson had interests in manufacturing in Maryland and the buying and selling of coal fields in Pennsylvania, Maryland and Virginia. He owned the Pioneer Cotton Factory in Georgetown, District of Columbia, and was a large stockholder in several Maryland cotton mills, the Baltimore Coal Company, the Maryland Colonization Society and the Susquehanna Canal Company.

In 1820, Wilson married Hannah Houlton in Baltimore. We were able to document the marriage at the Hall of Records in Annapolis, although the record there shows the bride's last

name as Houston. They had two children, a girl who died when she was five, and a boy who lived only eight months.

Shortly before his son died, Wilson was advised that a change of air might help the dying boy. Wilson took him for a ride a few miles outside the city. That evening the child was much brighter and livelier. Although the improvement lasted only a short time, the impression of the effects of the change of air remained in Wilson's mind throughout the rest of his life. And he left part of his fortune for the establishment of the Thomas Wilson Sanitarium for Children.

This trust established in his will was not the first evidence of his interest in child welfare. Thomas Wilson served as president of the Baltimore Association for Improving the Condition of the Poor and the Baltimore Manual Labor School for Indigent Boys.

His death certificate lists the date as September 2, 1879, and his age as 90 years, 6 months and 27 days. He is described as a widower and capitalist, and his residence was 127 McCulloh Street.

He is buried in Greenmount Cemetery not far from his friend, Enoch Pratt. The tombstone says that Wilson was the founder of the Sanitarium for Children and the Thomas Wilson Fuel Saving Society.

The Fuel Saving Society is still functioning and is listed in the Baltimore telephone directory. The Society was established to help soften the financial hardships the need for fuel each winter caused among the poor, by allowing them to make year 'round deposits with the Society and being assured of adequate fuel during the cold months.

Greenmount Cemetery contained one surprise, however. The woman buried next to Wilson is not the Hannah whom he had married in 1820, but a Julia Ann Wilson, who died in 1868 at age 79. The Baltimore City Court House has neither a record of Hannah's death nor one of Wilson's marriage to Julia Ann, but does have a record of Julia Ann's will drawn up in 1833, mentioning Wilson as her husband and an adopted daughter. Therefore, sometime between the birth of the second child and 1833, Wilson lost his first wife along with the two children.

Hannah and the two children are not buried in Greenmount Cemetery. A check at the Baltimore Cemetery, in which Wilson owned stock, turned up two Hannah Wilsons, but the dates on the head markers and the names of the other persons buried in the same plot do not correspond with Wilson's known family.

That Wilson has been largely forgotten is evidenced by the fact that there has been no record of any visitors to the gravesite in Greenmount Cemetery and there is no correspondence in the file.

In his will, Thomas Wilson provided for the Thomas Wilson Sanitarium for Children of Baltimore with the following remarks by way of introduction,

> "I have observed for many years with much concern the great and alarming mortality which occur each summer among young children deprived by misfortune of their parents, of all opportunity for removal from the heat and fatal atmosphere of the city. God, in his providence, did not spare to me my children to be the solace of my declining years, but my pity for the sufferings of little children and of their parents is none the less. And I do not think that I can make a better use of some of the means of which God has made me steward than in the alleviation of the pains and in the prolongation of the lives of those of whom our Savior said "Suffer the little children to come unto me for such is the Kingdom of Heaven."

In the Preface to the book, *Sanitary Care and Treatment of Children and Their Diseases,* prepared by request of the Trustees of the Thomas Wilson Sanitarium of Baltimore, Maryland, in 1881, it states,

> "The public may also be interested in knowing that the trustees have purchased a farm of 150 acres for the sanitarium, on the Western Maryland Railroad, nine miles northwest of Baltimore in a neighborhood long known for its salubrious air, highly cultivated land and intelligent population.
>
> It is probable that the trustees will begin their work in very simple and inexpensive houses and decide upon permanent buildings after they have had the experience of several years in the management of their trust."

The book just quoted contained a series of five essays and also a building plan proposed in one of the essays by J. Lewis Smith, MD and that was

prepared by Mr. John Beverly Robinson, architect, New York. This building was never constructed and the conservatism of the trustees in not having it constructed was rewarded when the sanitarium was no longer needed.

In establishing this institution it was not the intent of the trustees to establish a hospital, but rather a summer retreat "for sick children under the most hygienic and local conditions that the neighborhood of Baltimore may afford."

One part of the grounds was to be devoted to day excursions, and the other part for the care and treatment of children who must be kept a number of days for recovery from sickness. Since the abnormal death rate during the summer was primarily in children under two years of age, this was the group to be treated at the Sanitarium. Mothers were taken with their infants and when a mother had other children under six years of age who could not be left at home, they too were taken with the children.

A day excursion to the Sanitarium included these meals:

> Lunch at 9:00 A.M.—Bread, butter, crackers and tea
>
> Dinner at 12:30 P.M. — Soup, roast or boiled meat, vegetables, bread, butter, milk and tea
>
> Supper at 5:00 P.M.—Bread, butter, crackers, milk and tea

A branch track of the Western Maryland Railroad led directly into the center of the grounds. A train left Hillen Station for the Thomas Wilson Sanitarium of Baltimore at 7:20 A.M. A wagonette drawn by two horses met the train at Mt. Wilson and carried the children to the Sanitarium. After the 5:00 P.M. supper, the train took the children back to Baltimore.

Tickets for the train rides and the day's excursions were given to patients considered in need of treatment by physicians and nurses in Baltimore. Four days of the week, the Sanitarium was to be used by white persons and by Negroes the fifth.

The first superintendent and physician was James Hall Mason Knox, Jr., MD. The Sanitarium was managed by Colonel John A. Tompkins, who was also one of the trustees of the Sanitarium.

The Sanitarium was open from June until September. The number of children cared for ranged from fifty to one hundred at a time. The figures for 1911 show that 3,596 sick children were cared for, 1,799 mothers and 507 well children visited the Sanitarium. Out of 301 patients that stayed at the hospital for treatment that year, 13 stayed less than two days, 190 patients were there from two to fourteen days, 76 children stayed from fifteen to thirty days, and 22 were at the Sanitarium for longer than 31 days.

In 1892, the buildings designed for the Sanitarium were completed. There was an Administration Building, a kitchen and dining room building, a cottage for workers, a laundry, a bath house, an engine house, a boiler house, and three wards for patients. There were three small cottages, of two rooms each, for separate or isolated cases and a laboratory.

The wards were one-story, wooden buildings; two were 92 feet long by 55 feet wide and one was 115 feet long by 56 feet wide. The wards were well-ventilated and were steam heated.

The summer retreat for children was necessary because of the poor sanitary conditions in the city in the summer and the lack of social and welfare agencies to assist the children affected by what was generally termed "summer complaint." When the Sanitarium was closed in April, 1914, there was no longer a need for children to leave the city. Sanitation had improved, and there were public agencies to lend a hand to needy families.

In the April 29, 1914, issue of the Evening Sun the following item appeared: "The Thomas Wilson Sanitarium today dismissed the last of its small charges and the duty of caring for the babies in the coming months will fall on the nurses of the Babies Milk Fund Association."

When the Thomas Wilson Sanitarium for Children closed, some of the children who had no parents were placed with nearby families. The infant summer work was turned over to the Happy Hills Hospital; this later became a permanent all-year-around ward.

Thomas Wilson's name, continued to be associated with care for the children of Baltimore. On July 1, 1923, child health centers called Thomas Wilson Welfare Stations were organized in Highlandtown, Curtis Bay, Brooklyn and Fairfield. These were comparable to today's well-baby clinics and were later taken over by the City Health Department.

During the 1930's there was a Thomas Wilson

House which was essentially a child welfare station, rendering preventive health services. Three nurses were attached to the station and infant welfare sessions were held each afternoon except Saturday, and on Saturday mornings. In April of 1934, the Thomas Wilson House had under supervision some 1,700 infants and young children under six.

Today, there are still two child health areas giving recognition to the wishes of Thomas Wilson that his money be used for the children of Baltimore City. "Thomas Wilson Wards" are located at both Happy Hills Hospital and in the Pediatric Ward of Union Memorial Hospital.

The *Annual Reports of the Board of Managers of the Maryland Tuberculosis Sanitorium,* October 1, 1924, contains the following sentence:

> "The purchase of Mt. Wilson was made on advantageous terms, largely due to the desire of the Thomas Wilson Sanitarium Board to make perpetual the use of the property for humanitarian purposes, especially for the welfare of children."

The buildings, land, livestock and equipment at Mt. Wilson, Maryland, owned by the Thomas Wilson Sanitarium Board were sold to the State for $110,000 in 1924. Some alterations were made to the property; a modern sewerage system and heating system were added, and the railroad siding was rebuilt, but the buildings were found to be fairly adaptable for the treatment of tuberculosis.

In 1926, the hospital was called the *Preventorium for Children.* In 1927-1928, the name was the *Mt. Wilson Sanitarium for White Patients* and was open to white women and children over six years old suffering from pulmonary tuberculosis. There were no proper facilities for the care of bed patients, nor for men, and admissions were limited to women and children who were ambulatory cases. In 1929-1930, Mt. Wilson was opened to white men as well.

In 1939, the legislature made $55,000 available for Mt. Wilson for operating room facilities and beds for a maximum of 40 additional patients.

The large brick 300-bed structure that was the last addition to the Mt. Wilson Hospital was formally presented to the State Health Department February 26, 1953. This $3,000,000 addition, with the 115-bed original building, made Mt. Wilson the largest TB Hospital in Maryland.

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This large modern hospital now stands on the grounds of the Thomas Wilson Sanitarium for Children. But, serving as a reminder of a by-gone era and need, there are still several of the original buildings on the grounds and the railroad tracks still pass the old, white Victorian house where the wagonette waited to pick up the children to carry them up on the hill for a day excursion in the country air.

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Vertical Files in the Maryland Room of the Enoch Pratt Free Library: *Thomas Wilson Sanitarium for Children; Thomas Wilson House; Mt. Wilson State Hospital; Thomas Wilson.*

THE EVOLUTION OF PUBLIC MEDICAL CARE IN BALTIMORE CITY

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The Social Security Amendments of 1965 are bringing about significant changes in the organization of public medical care services in Baltimore City. The Medical Care Program for the Indigent which began in Baltimore in 1948 came to a close when Title XIX of the Social Security Amendments took effect on July 1, 1966. At this juncture, it is of interest to review the evolution of public medical care in Baltimore City.

Public Assistance

The Elizabethan statutes of England, which required local parishes to aid the poor, had their influence in the New World and often served as the pattern for the welfare laws enacted in the American colonies. In most instances the provisions adopted in this country in the late seventeenth century for the relief of the poor and the sick were akin to the measures contained in England's Poor Law Act of 1598. Some departures from the "Poor Law" occurred in America, the most important one being the vesting of public responsibility for aiding the poor in the hands of local government, rather than in the parish (the ecclesiastical unit).

The Elizabethan Poor Law provided "indoor" or institutional relief in the forms of "poor houses" for the "impotent and the aged," "work houses" for the able-bodied, employable poor, and "houses of correction" for the "rogues" and "beggars.[1]" However, the sparsely populated colonies could not afford the expense of maintaining separate institutions for the several groups of indigent. Usually the local government maintained an "almshouse" or "poor farm" to which all the indigent, the sick and the disabled were sent. This was still the common practice in the United States in the late 19th and early 20th centuries.

Subsequently institutional relief was supplemented by "outdoor relief" to needy persons who continued to reside in the community. It was sometimes provided through the efforts of local charitable or volunteer organizations.

All public welfare services were in the domain of local and state governments. Federal participation was limited to rare instances of aid to farm areas in need of relief because of natural catastrophes. The American Red Cross, established in 1888, assisted in the provision of such relief.

The federal government became actively involved in public welfare in 1912 with the establishment of the Children's Bureau. This was followed by the enactment of special laws by several states to provide *outdoor* relief to widows, needy children, the blind and the old. Thus the categorizaton of the poor and the needy began.

The Great Depression (1930-1935) brought radical changes in the administration and financing of relief in the United States. Because of

Excerpts from a chapter in the author's dissertation for the doctor of public health degree, The Johns Ropkins University, 1966.

large scale unemployment throughout the country, what had been a local responsibility became a national concern. Millions of people needed help. Interim relief was provided through the Emergency Relief Administration of the federal government. The idea of federal grants-in-aid to the states for assistance to the poor was developed during the depression years. The Social Security Act of 1935 incorporated the grants-in-aid mechanism and established it on a permanent basis.

The Social Security Act—Under the Social Security Act federal grants-in-aid were provided to assist designated categories of recipients—the aged, the blind, and mothers with dependent children. In order to be eligible for grants, the states were required to conform to certain federal regulations. As a result, the State of Maryland formally established the three federal categories of public assistance through the provision of Old Age Assistance for needy men and women 65 years of age or over (OAA), Aid to the Blind (AB), and Aid to Dependent Children below 18 years of age whose parents were dead, incapacitated or absent from home (ADC). Although the Social Security program does not provide federal grants-in-aid to help the General Public Assistance (GPA) category, Maryland has continued to assist persons in this category from its own funds. GPA generally includes individuals who are not eligible for assistance under the provisions of the Social Security Act. It also provides for the partially employable who are at a disadvantage in the labor market.

Since 1935, amendments to the Social Security Act have liberalized the public assistance program. A fourth federal category was covered in 1950 with the provision of Aid to the Permanently and Totally Disabled (APTD). In 1960 another category was created under the Kerr-Mills Act: with Medical Assistance for the Aged (MAA), it not only liberalized federal grants to the states for medical care to OAA recipients, but also provided the same benefits to individuals 65 years and over who are not financially eligible for OAA but require assistance in meeting the extraordinary costs of medical care. In Maryland the MAA program began operations on June 1, 1961.[2] Owing to the more liberal federal reimbursement provisions of MAA and to the increase in Social Security benefits, some OAA clients were transferred to MAA.

The ADC category has also undergone some changes. In 1950, the category of beneficiaries was expanded to include the parent or adult who cares for the dependent children. In 1961 and 1963 further amendments permitted the extension of assistance to families with children whose parents are at home but unemployed. Since 1963 the program has been known as Aid to Families with Dependent Children (AFDC).

Substantial federal involvement in the provision of medical care services to public assistance clients was effected through amendments to the Social Security Act in 1950, 1956, and 1958. The original act permitted very limited financial participation by the federal government in paying for medical care. The 1950 amendment allowed federal reimbursement for "vendor payments" (direct payments to providers of medical care services), as long as the sum of payments for medical care and for the individual's cash assistance did not exceed the federally matchable maximum. Federal sharing of vendor payments for medical care was increased by the amendments of 1956 and 1958.[3] As already noted, the amendments of 1960 and 1961 increased federal participation in the cost of medical care services to recipients of old-age assistance and created the additional MAA program.

In 1951, total expenditures on vendor payments for public medical care programs in the United States amounted to $48.1 million. By 1964, expenditures exceeded $1.0 billion,[4] largely as a result of the 1950 and subsequent Social Security Act Amendments.

The Social Security Amendments of 1965 envisaged major changes in the public medical care programs, in addition to creating Medicare for the Aged. Title XIX, which takes effect in stages over 10 years, provides for medical assistance to medically indigent persons under 65 years of age and insists on uniform treatment of all public assistance categories.

State of Maryland—The Charter of Maryland was granted by the English Crown to Cecil Calvert (Lord Baltimore) in 1632 and the first colonists arrived in 1633.[5] A law concerning public welfare in Maryland was enacted as early as 1650. The law required that "all maimed, lame or blind persons within the county of St. Mary's"[6] be provided with maintenance from

public funds. The principal means employed by local government to assist needy citizens was the public almshouse. Tax funds were also used to grant financial subsidies to charitable institutions that concerned themselves with assisting the sick poor, the disabled and the needy. The first such subsidy to a private institution in Maryland is said[7a] to have been given in 1798 to Frederick County College, which admitted needy students. Grants for aiding the sick poor were given to hospitals and dispensaries, but these were lump subsidies that were not directly related to the cost of care given to the poor. The State of Maryland continued this method of subsidizing private and social agencies for almost two centuries, because the State thought that "it was cheaper for the State to support organizations outside State control and management."[8]

In 1900 the Maryland legislature[9] created a Board of State Aid and Charities, the principal function of which was to supervise the disbursement of tax funds to local institutions aiding the poor. This Board was reorganized in 1935[7b] to conform to the Federal Social Security Act. Later the Board became the official agency charged with distributing emergency relief funds obtained from the federal Emergency Relief Administration. Between 1935 and June 1, 1939, all county welfare boards and the Department of Public Welfare of Baltimore City (which came into existence on January 10, 1935)[10a] were subject to supervision by the Board. On June 1, 1939, the Board of State Aid and Charities was abolished and replaced by the Maryland State Board of Public Welfare.[11]

Legislation for aiding the blind in Maryland was passed in 1860.[12] Beginning in 1916 indigent widows and their children were assisted.[13] The first old age pension was paid in 1927,[14] with the aged (65 years and over) poor receiving up to $1 a day.

Aside from unemployment compensation, there is no State law that requires the counties or Baltimore City to provide assistance to the unemployed or unemployable. However, the State provides some assistance through the General Public Assistance program (GPA). Public assistance programs contain three components, namely, a cash payment for food, clothing and shelter; provision for medical care; and social services.

The State of Maryland has always been a leader among the states in complying with federal legislation in order to improve its public assistance program.

Public Medical Care in Baltimore City

The events leading to the establishment of Baltimore City's Medical Care program for the Indigent (MCI) can be roughly grouped between two time periods—before 1935 and 1935-1948.

Prior to 1935—As noted, earlier, the State of Maryland has always provided some care for its poor at public expense. This is also true of Baltimore City. The first public infirmary in Baltimore City was opened in 1776 or 1777,[15] together with a large almshouse near the old Richmond Market. The sick poor received care at both places. In 1797, the State Legislature authorized another public hospital to care for the "indigent sick and lunatics," which was located at the present site of The Johns Hopkins Hospital. This hospital is known to have operated for 20 years. In 1865 a new "mixed almshouse with hospital features" specifically for the care of the indigent sick was built at a cost of $50,000 on a 300-acre farm at Bayview[16a] under the administrative responsibility of the "town overseers of the poor." This institution became known as the Baltimore City Hospital and is still in existence. In 1909, another institution, Sydenham Hospital, was opened by the city to take care of patients with infectious diseases. It was later converted to other uses as the Montebello State Hospital for Chronic Diseases.

The voluntary (non-profit) general hospitals in the Baltimore area have also cared for the indigent sick. In addition, University Hospital, staffed by the University of Maryland School of Medicine, has served them. The costs of such care were met either through endowment funds or charitable contributions, or from lump-sum grants of tax funds made by the Board of State Aid and Charities.

In 1927, the city had 50 dispensaries[16b] that cared for the poor—14 operated by the City Health Department, 16 by general hospitals and 20 by other philanthropic agencies. Although there is only scant evidence of any unified effort in the late 1920s to take care of the sick poor, there is ample evidence that both private institutions and the city government were alive to their medical needs.

1935- 1948—With the formation of Baltimore City's Department of Public Welfare in 1935, a shift occurred in responsibilty for medical care to the indigent. All but eight dispensaries closed. The Department operated six public clinics[10b] that were kept open two hours a day for six days a week. Two private dispensaries, subsidized through grants from the Department of Public Welfare, rendered similar services to the poor. In addition to the eight dispensaries, the Department also arranged for the handling of emergency calls from persons unable to travel to a dispensary or to a hospital. In the daytime, emergency calls were answered by physicians staffing the dispensaries, while at night the calls were linked with the telephone switchboard of the City Fire Department, which sought a physician from a list furnished by the Department of Public Welfare.[10c] Physicians were paid a fee per visit for house calls and "per session" for the time spent at a dispensary.

The Department also administered the Baltimore City Hospital to which most of the needy sick were directed. In addition, the Department entered into contracts with voluntary (non-profit) general hospitals in the area to care for the indigent who were seriously ill. The hospitals were reimbursed uniformly at a stated patient day rate, which was increased in several steps over the years and amounted to $10 per day in 1947.[17]

With the passage of the Social Security Act of 1935, the need for providing adequate medical care for all categories was keenly felt by the Department of Public Welfare. The Department became aware of the need to coordinate its medical care activities, and its annual report of 1935 asked for the creation of a position of "Assistant Director of Public Welfare to be filled by a physician,"[10c] and cited the need for a comprehensive survey to estimate the medical care needs of the indigent in Baltimore and the surrounding counties. These two requests recurred in every annual report of the Department for the next five years, with little or no effect. At that time there was widespread discussion of socialized medicine and national health insurance in Maryland and throughout the nation, as a result of President Roosevelt's interest in compulsory national health insurance and of the earlier report of the Committee on the Costs of Medical Care.[18] With the Wagner Health Bill (1939) pending before Congress, the professional and lay leaders in Baltimore were actively concerned with its implications.

Following discussions of the bill by a small professonal group, known as the "Saturday Night Club,"[19a] an "All-Maryland Health Conference" was convened, largely through the efforts of Dr. Henry E. Sigerist of The Johns Hopkins medical faculty. The conference was held at The Johns Hopkins School of Hygiene and Public Health on May 27 and 28, 1939. Approximately 100 organizations were represented. Although the primary purpose of the conference was to enlist support for the Wagner Bill, one of its by-products was the documentation of the medical care needs of the indigent and medically indigent by Dr. Maurice C. Pincoffs, chairman of the Department of Medicine of the University of Maryland School of Medicine.[19] Dr. Pincoffs proposed that a permanent subcommittee on medical care be established under the State Planning Commission to study the medical care needs of the people of the State and to suggest improvements as necessary. The conference endorsed Dr. Pincoff's suggestion and referred it to a committee for further study, where it was shelved.[20a] The strong views of a labor leader[20b] who participated in the conference are credited with awakening the Medical and Chirurgical Faculty of the State of Maryland to the desirability of concerning itself on a voluntary basis with the problems of the indigent sick. On August 23, 1939, the Medical and Chirurgical Faculty took action by requesting Dr. Abel Wolman, chairman of the Maryland State Planning Commission, to appoint a committee on medical care to survey the medical care needs of Baltimore and the surrounding counties of Maryland.[20a]

The appointed committee under the chairmanship of Dr. Pincoffs, held its first meeting on January 23, 1940. It gave priority of attention to the needs of the counties, where organized facilities for medical care were greatly lacking in comparison with those in Baltimore City. World War II intervened, and Dr. Pincoffs volunteered for military duty. Dr. Victor F. Cullen assumed chairmanship of the committee and a brief report, issued on April 15, 1944, recommended that an organized medical care program be established in each of the 23 counties of Maryland. The recommendation was endorsed by the Medical and Chirurgical Faculty. In 1945 the State Legislature

approved a medical care program for the indigent and medically indigent in the counties of Maryland under the aegis of the State Department of Health.[20a]

In Baltimore City, the Department of Public Welfare continued as the official agency responsible for the medical care of the indigent. With the launching of an organized medical care program for the indigent in the counties, the Department persuaded the Mayor of Baltimore City to accede to its repeated request to create the post of Assistant Director of Welfare for Medical Care. Dr. Ross Camerson, a physician, was appointed to the post on July 1, 1945.[21] He received the additional title of Deputy Commissioner of Health in the City Health Department for liaison purposes, ie, to facilitate a close working relationship between the Baltimore City Health Department and the City's Department of Public Welfare.

On August 5, 1944 the State Planning Commission had nominated Dr. Lowell J. Reed of The Johns Hopkins University to chair a committee to study the "medical care needs of Baltimore City"[22] and make recommendations to the city and state governments. The Reed Committee submitted its report in December 1946.[23a] It recommended the adoption of an "organized plan for meeting the medical care needs of the recipients of public assistance" and the establishment of a "Medical Care Section" in the City Health Department to discharge the functions specified by the plan.[23b] The committee also recommended that responsibility for administering the program be vested in the City Health Department.

The suggested plan[23c] for organizing a medical care program for public assistance recipients in the City was quite different from the plan in effect in the counties. The differences lay in the method of paying physicians and in the additional provision, for Baltimore City, of separate clinics in the City's hospitals as an additional source of medical care. The plan for the City prescribed a capitation method of payment whereas in the counties the physicians were paid on a fee-for-service basis.

Separate clinics, which had no counterpart in the counties, were recommended for Baltimore City in order to take advantage of the greater medical facilities available there and to ensure the provision of comprehensive care for the indigent through the "integration of the facilities of the hospital dispensary and the services of the physicians practicing in the area."[23d] The originators also had in mind the opportunities that such an *integration* would provide for the education of medical students and house staff, and for the continuing education of private practitioners.

The capitation method of paying physicians was proposed for the City program in the belief that "this plan will permit greater freedom in the referral of any individual to his personal physician by the 'Medical Center'," and vice versa.[23e] Administrative ease, reduction of paper work by the practitioner, and the desire to predict and control expenditures were the other considerations that prompted the Reed Committee to recommend the capitation method for paying physicians.

The State Legislature approved all the recommendations of the Reed Committee, and the new law, Chapter 714 of the Maryland State Laws of 1947, was signed on April 25, 1947. This law charged the Baltimore City Health Department with administering a medical care program for the indigent by establishing a Medical Care Section.

The text of the law reads as follows:

> Within the provisions of the budget for the program of medical care, monies for the care of the indigent persons in Baltimore City shall be transferred to the Mayor and City Council of Baltimore and the administration of the program in Baltimore City shall be administered under the Commission of Health of the City by a Medical Care Section in Baltimore City Health Department in accordance with plans that shall be prepared by the Baltimore City Health Department and submitted to and approved by the State Board of Health: and for these purposes the Commissioner of Health of Baltimore City is hereby authorized to contract with physicians, dentists, hospitals, or other accredited agencies for the medical, surgical, hospital or other medical or nursing care of eligible persons; and also to appoint such personnel as may be necessary within the provisions of the budget and in accordance with the provisions of the Baltimore City Charter.[24]

The new law became effective on June 1, 1947. As required by a recommendation in the Reed Committee Report, the Mayor announced the appointment of an advisory Committee on Medical Care when the Medical Care Section of the Baltimore City Health Department was inaugurated on September 4.[25] The Commissioner of Health appointed the members of the Committee and the Committee elected its own chairman with a tenure of three years.[26]

Unlike the State Council on Medical Care, which is a legally constituted advisory body serv-

ing the State Board of Health, the City's Advisory Committee had no legal standing. The Committee was established principally to afford representation to the professional and lay groups that have a direct interest in medical care for the indigent. The composition of the Committee was flexible and consisted of 10 to 15 members who represented the medical societies, hospitals, medical schools, pharmacists, nurses, dentists, State Health Department, State Board of Health, City Welfare Department and the City Health Department. The Director of the Medical Care Section served as the secretary of the committee, which met approximately three times a year. It performed the useful functions of eliciting a consensus of the several professional and lay groups on matters directly affecting the administration of the Medical Care program for the Indigent (MCI) and conveying it to the State Council on Medical Care and to the City Health Department for their guidance. From time to time the Committee also studied specific problems of the program and offered constructive solutions.

It took ten months of hard work by the new Medical Care Section of the City Health Department to launch the MCI program. With the formal signing of contracts with The Johns Hopkins and University Hospitals, the program began on June 15, 1948.[27] Newspapers and professional journals hailed the program as a shining example of a city's efforts to solve its health problems.[28,29]

Dr. Wendell R. Ames, who became the director of the Medical Care Section on Sept 10, 1947, held office briefly and was succeeded by Dr. J. Wilfred Davis on June 2, 1948.[30] Dr. Davis directed the program for 17 years until his retirement in October 1965.

Within two months after the signing of contracts with The Johns Hopkins and University Hospitals, a medical care clinic was established at each and five other hospital clinics were subsequently added to the program, in the following order:

1. The Johns Hopkins Hospital, Aug 2, 1948.[31]
2. University Hospital, Aug 9, 1948.[31]
3. South Baltimore General Hospital, April 1, 1949.[32]
4. Sinai Hospital of Baltimore, Inc., May 1, 1949.[32]
5. Provident Hospital, June 1, 1949.[32]
6. Mercy Hospital, Inc., Dec 1, 1949.[32]
7. Baltimore City Hospitals, Aug 31, 1953.[3]

The public dispensaries, hitherto operated by the Department of Public Welfare and private organizations, were closed one by one after the Medical Care program for the Indigent went into operation. All but two were closed by 1950. The Baltimore Eastern Dispensary, under voluntary auspices, closed in 1964. The Curtis Bay Dispensary is the only survivor. It renders first aid, and is operated by the Department of Public Welfare only because the area has no medical center nearby. This dispensary may be closed as soon as the South Baltimore General Hospital moves from its present location to the new one, close to the Curtis Bay area.

Hospital inpatient care could not become part of Baltimore City's MCI program because certain city health officials were at that time reluctant to assume too many responsibilities in providing "curative medical care." The result was that the State Health Department had to assume responsibility for the inpatient program. In the counties, too, the State Health Department assumed the responsibility for inpatient care, since many county clients had to go to hospitals in Baltimore City or in another county.

From its inception in 1947, Baltimore City's MCI program grew steadily in size. For many years, however, the method of operation remained essentially as envisaged in the plan proposed by the Reed Committee. In June 1961, the Medical Assistance for the Aged (MAA) program became the additional responsibility of the Medical Care Section and it provided for a fee-for-service method of reimbursing physicians. This was followed, on Jan 1, 1963, by the adoption of the same method for the MCI program.

Reasons for Change

Under both the capitation and fee-for-service methods the client has had the free choice of a personal physician. Under capitation, however, the client usually obtained all of his care from the same physician. If for any reason the client or the doctor wanted a change, it was possible to arrange it, but only with the knowledge and consent of the Medical Care Section of the City Health Depart-

ment. Under the fee-for-service method the client has complete freedom to visit any licensed physician in the community without notifying the Medical Care Section in advance.

As noted earlier, the Reed Committee proposed capitation in 1946 in the belief that under this method of payment both the physician and the medical care clinic would have greater freedom than under fee-for-service in referring clients to each other.[23c] The Committee believed that referrals for specialist care would enhance opportunities for educating the referring practicing physician, as well as the young physicians in training at the two teaching institutions (The Johns Hopkins and University Hospitals) where the first medical care clinics were established. The administrative ease of the capitation method, with the absence of detailed recording or billing procedures for services rendered, was another important consideration. The Committee also believed that the capitation method might be cheaper.

The minutes of the meetings of the Baltimore City Advisory Committee on Medical Care show that the representatives of the Medical and Chirurgical Faculty of Baltimore City frequently expressed dissatisfaction with the capitation method, although the medical society had unanimously approved it in 1947. The public acclaim following the inauguration of the MCI program facilitated its initial acceptance by the medical society. The strong endorsement of the program by the medical society is also credited to its sponsorship by Dr. Maurice C. Pincoffs, in whom the society had great confidence. However, since the county program in Maryland had been paying physicians on a fee-for-service basis since its inception in 1945, many physicians who had indigent clients from the counties as well as the city began to complain about the inconvenience of operating under two different methods of payment. In 1953, the Baltimore County Medical Association in conjunction with the Maryland Academy of General Practice criticized the capitation method in the MCI program and asked for the immediate institution of fee-for-service.[34]

Whenever complaints were aired at the meetings of the Advisory Committee, Dr. Pincoffs defended the capitation method. The issue was not joined for 12 years until Dr. Pincoffs withdrew from active participation in 1960. After his departure the idea of fee-for-service was revived with increased vigor and with strengthened support from the medical society. In the course of time the administration of the Medical Care Section also became more receptive to fee-for-service, for it was experiencing increasing difficulty in finding physicians willing to care for the growing number of new clients. Moreover, the legislators and the authorities controlling the budget of the city government had never really understood the capitation method. The result was that the capitation fee remained the same for 15 years. The repeated complaints of officials that the capitation method was "foreign" and "unfair" because the doctors "get paid whether they see a patient or not" gained momentum by the beginning of 1961. At that time the Medical Care Section was preparing to launch the Medical Assistance for the Aged (MAA) program. The Health Department was convinced that paying on the existing capitation basis would be inequitable toward physicians who care for a good many elderly clients, because the aged use more services, on the average, than younger clients. The Medical Care Section did not favor setting a higher capitation fee for MAA clients, because it regarded two rates of payment as impracticable. The administration, as well as some members of the Advisory Committee, preferred to launch the MAA program with fee-for-service.[35a] The MAA program would also provide an opportunity to test the feasibility of the fee-for-service method for the MCI program in Baltimore and to ascertain whether fee-for-service attracted large numbers of physicians to the program.

A resolution recommending the adoption of fee-for-service for the MAA program was adopted by the Advisory Committee on Jan 25, 1961.[35b] Much to the satisfaction of the physicians, the fee-for-service method made its debut in Baltimore City through the MAA program on June 1, 1961. The pressure from physicians urging that the same method be employed for the MCI program intensified. The experience gained by the Medical Care Section with fee-for-service persuaded the Health Department of its efficacy. A resolution recommending the fee-for-service method of paying physicians in the MCI program was passed by the Advisory Committee on Oct 24, 1962, to become effective on Jan 1, 1963.[36]

Physicians were paid per visit. The schedule of fees was as follows:

Office visit	$2.50
Home day visit (8 AM to 8 PM)	$3.50
Home night visit (8 PM to 8 AM)	$4.50

Since July 1, 1966, the MCI program has formally ceased to exist. In its place a new enlarged program has been established. The new program provides for medical care services to the medically indigent as well. A medically indigent person is defined as a person who is not receiving public assistance, but who is unable through his own resources, or resources available to him, to provide himself and his dependents with proper medical care. Single persons with a maximum family income of up to $1,800, a family of two with a maximum of $2,280, and a family of six with a maximum of $3,960, qualify for medical care services through the new program. It is estimated that nearly 120,000 medically indigent together with about 80,000 public assistance recipients will be covered by the new public medical care program in Baltimore City.

Under the new program there has been a 50¢ increase in the fee for an office visit to the physician. Judged by prevailing standards, these fees are low.

The seven medical care clinics that existed under the old program are no longer in operation. Public medical care recipients are now free to go to any hospital outpatient clinic or any private physician for medical care.

Summary

The Medical Care Program for the Indigent began in Baltimore City in 1948 and the program operated for nearly 15 years without major changes. The Medical Care Section launched the MAA program in June 1961 with a provision to reimburse physicians on a fee-for-service basis. This was soon followed by a change in the MCI program's method of paying physicians from capitation to fee-for-service. The passage of the Social Security Amendments of 1965 resulted in the cessation of the old MCI program and the establishment of a larger program to serve both the indigent and medically indigent in Baltimore City.

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THE PHYSIOLOGY OF THE PLACENTA AS IT AFFECTS THE HEALTH OF THE FETUS

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We have begun to think of the placenta as we think of the girl next door: We always knew that she was there, we have taken her for granted, sometimes we have thrown her aside unfeelingly, but now, as scientists, we are beginning to appreciate her in her maturity. And I might even add that hormones have played a role in our changed attitude.

Table 1

PLACENTAL FUNCTIONS

- Respiratory exchange
- Immunologic barrier
- Endocrine gland
- Alimentary organ
- Biosynthetic organ
- Excretory organ

The placenta functions as the main organ of homeostatis for the fetus. Table 1 lists many of these functions. The placenta is an organ of respiratory exchange: in effect, the fetal "lung." It is an immunologic barrier that prevents interactions between the mother and the fetus which would otherwise be detrimental. It is an endocrine gland, secreting gonadotropin, progesterone and estrogen, and perhaps a growth hormone-like substance and adrenal steroids. It is an alimentary organ: the fetal "gut." It is, a biosynthetic organ with ability to form a number of proteins and complex metabolites: the fetal "liver." And finally, the placenta is also an excretory organ: the fetal "kidney." Anyone who doubts this should give attention to the baby with bilateral renal agenesis, who is born with an essentially normal blood urea nitrogen (BUN) which then rises after the placenta is discarded.

The placenta has a definite evolution and lifespan. The primitive blastocyst is free floating until about seven days after ovulation, when it settles into the endometrium and begins nidation. At that stage it is a sphere of cells destined to become trophoblast, surrounding a much smaller disc of cells destined to become embryo. With nidation, the trophoblast cells proliferate rapidly and burrow into the endometrium. At this stage both trophoblast and embryo are nourished by diffusion. However, by 24 days there is formation of maternal blood lakes, and a primitive embryonic circulation develops. The trophoblast is by then differentiated into a cellular, dividing cytotrophoblast and a syncytial, nondividing syntrophoblast.

With time, recognizable villi develop. These are

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fingerlike projections of tissue of fetal origin, projecting down into maternal blood lakes. The outer layer of the villus is syntrophoblast, then cytotrophoblast, then connective tissue and finally fetal capillaries. As pregnancy proceeds, there is a progressive thinning out of the cytotrophoblast layer, and towards the end of pregnancy it is absent in places. There is always, however, a continuous layer of syntrophoblast between fetal and maternal tissues. The relative amount of connective tissue decreases towards the end of pregnancy while the density of fetal capillaries increases. This has the effect of decreasing the distance between the fetal and maternal blood streams and aids diffusion as the volume of the embryo increases.

Towards the end of pregnancy, senescent changes begin to take place in the placenta. Individual villi become hyalinized and nonfunctional. The increase of placental blood flow fails to keep pace with the increase of fetal size. In some cases small infarcts develop in the placenta. The pace of these changes varies greatly, and some placentas survive in good functional condition well beyond the normal 40 weeks of gestation. In other cases, the placenta is already declining in its function before the child is born. In the case of multiple pregnancy, the volume of fetal tissue is so great that even a normal placenta is unable to accommodate it towards the end of pregnancy. All these factors may contribute to placental insufficiency syndromes, to be described later.

Experimental evidence that the placenta has a finite lifespan, after which it is no longer ideal as an organ of support, is provided by transplantation experiments carried out by Simmons and Weintraub.[1] These investigators transplanted fragments of trophoblast or fertilized ova beneath the kidney capsule of the mouse. They found that placental fragments transplanted at progressively later stages of gestation survived for progressively shorter intervals of time. They all degenerated by about the same time that the pregnancy would normally have terminated: in particular, in the mouse, about 25 to 30 days after conception. The implication is that there is some sort of biological clock in the placenta which dictates its senescence whether or not it is related to an embryo and whether or not it is in its normal location. This may be a protective mechanism that prevents a highly invasive tissue such as trophoblast from becoming a tumor after the birth of a fetus. Histologically, in fact, the trophoblast looks highly neoplastic. Yet only about 1 in 15,000 pregnancies results in choriocarcinoma.

It seems very peculiar indeed that the fetus, although genetically foreign, is accepted as a homograft by the mother for a period of nine months, although she would reject a skin graft from her husband in about nine days. There must be some sort of insulation between the fetus and the mother to prevent her from recognizing and attacking the fetus as a foreign tissue. Recent evidence suggests that the trophoblast and the fetal membranes together form such a barrier. Grafts of mouse trophoblast into a number of sites, including under the kidney capsule and the capsule of the testis, have demonstrated inability to sensitize to subsequent skin grafts.[2] It seems to be a particular property of the trophoblast that it fails to express histocompatibility antigens in a normal fashion. Yet there is no doubt whatsoever that the trophoblast is derived from fetal tissues, and genetically it should be like the fetus rather than like the mother.

The extreme experiment in this respect was done by Lanman et al,[3] who mated Rabbit A with Rabbit B, and then took the ovum from this mating and implanted it in Rabbit C. Thus neither on the father's side nor on the mother's side was the ovum related to the adoptive mother. Rabbit C had been sensitized by skin grafts from rabbits A and B, which she rejected. In this situation there was completely normal differentiation of the embryos, and the offspring were born alive at term, in spite of the fact that the mother was further sensitized by skin grafts from both Rabbit A and Rabbit B during the gestation. The mother sloughed the skin grafts at the same time that she was tolerating the fetuses. Among the many remarkable feats which the placenta performs, not the least is this peculiar immunologic separation of the fetus and mother.

Table 2

SIMPLE DIFFUSION

Oxygen
Carbon Dioxide
Water
Urea

The placenta has been most thoroughly investi-

gated in terms of its selective permeability. It is by virtue of the highly selective nature of its transfer function that the placenta is able to regulate the internal environment of the fetus to so large an extent. Table 2 lists a group of substances which apparently pass the placenta by simple diffusion. The transfer of blood gases in many ways resembles that which occurs in the lung. The partial pressure of oxygen is, however, much lower in the embryo, and one of the changes occurring immediately after birth is a large increase in P_{O2} appreciated by the tissues of the infant. Of clinical significance is the fact that water crosses the placenta readily, and if a mother is overhydrated during labor by the use of intravenous fluids, it is quite possible to have a water-intoxicated fetus who is born with convulsions and edema secondary to rapid shift of water across the placenta.

Table 3

HIGHLY PERMEABLE, MECHANISM UNKNOWN

Na, K, Cl, Co, Cu, SO4, Ca
Sex Steroids, Thiouracil
Sulfa, Salicylates
Tetracycline
Chloramphenicol
Phenothiazine
Barbiturates
Streptomycin

Table 3 lists a group of substances to which the placenta is highly permeable, but for which the transfer mechanism, if any, is unknown. Included are many ions, and one could readily conclude that metabolic abnormalities present in the mother would also be reflected in the fetus. Sex steroids acquired passively from the mother are responsible for the familiar breast engorgement encountered in neonates. Salicylates given to the mother in high dosage can result in bleeding in the newborn. Prophylthiouracil can cause an airway obstructing goiter in the baby. Diuril has been known to result in thrombocytopenic purpura. Barbiturates given for obstetrical anesthesia frequently cause depression in the newborn. And many of the antibiotics which might be given during the last trimester have potentially adverse effects upon the fetus. These include sulfonamides which compete with albumin binding of bilirubin, tetracycline which causes temporary growth arrest and discoloration of the teeth, and streptomycin which can cause deafness in the neonate.

Table 4

ACTIVE TRANSPORT

Amino Acids
Glucose, Fructose
Fatty Acids
Vitamins
Glycerol
Certain Antibodies
Fe, Zn, Iodide

Table 4 illustrates a group of substances that cross the placenta by active transport. You will recognize here a number of fundamental building blocks for tissue: amino acids, glucose, fatty acids and vitamins. How do we know that these substances are actively transported? In most cases the evidence is based upon finding higher concentrations in the fetus than in the mother.[4] Another line of evidence is illustrated in the case of iron. It is a common occurrence to have a baby born with 18 grams of hemoglobin from an anemic mother. If the mother is sufficiently anemic I believe that levels of iron can be achieved at which the baby also becomes anemic. But the baby evidently has first choice on a limited iron supply. Clement Smith et al[5] observed a similar effect with respect to other nutrients after the hunger winter in Holland. As you perhaps know, the last winter of the Nazi occupation was a very difficult one in Holland, and starvation was common. Many women were pregnant during this era and actually lost as much as 20 to 40 pounds during pregnancy. Smith's finding was that the birth weight of their babies was normal. Again the indication was that, despite an acute shortage of tissue building blocks, the fetus had first claim and grew at the expense of the mother.

It is a little difficult to harmonize this last finding with the common experience that babies in the less nourished areas of the world are normally smaller. A friend of mine, visiting from Indonesia, said, "If a premie is defined as 5½ lbs or less, most of our babies are premies." My own feeling is that racial differences play a role in birth size, and that chronic starvation may be more damaging than acute starvation following a

lifetime of adequate nutrition.

Table 5

GRADIENT, MECHANISM UNKNOWN

Adrenal Steroids
Thyroxin
Bilirubin
Cholesterol
Reserpine

Table 5 lists a group of substances which pass the placenta, but in which a significant gradient occurs between maternal and fetal concentrations. In some cases the gradient has been demonstrated experimentally by giving radioactively labeled substances to the mother and measuring the levels in the cord blood. The question is frequently raised whether the mother who is on pharmacologic doses of steroids will give birth to a baby whose pituitary-adrenal axis is suppressed. Although this is theoretically possible, in practice these infants have usually been able to make adrenal steroids in response to stress, and apparently are protected by the placental gradient. The completely athyrotic cretin receives some transplacental thyroid from his mother, but frequently not enough to protect him against intrauterine damage. Perhaps the most significant difference between the cretin who is already badly damaged at birth and the one who can be salvaged by prompt thyroid treatment is the degree to which the placenta of each has been permeable to maternal thyroxin.

With respect to bilirubin, we know that the Rh baby with severe disease may die in utero from anemia, but does not get kernicterus until after birth. The sharp rise in bilirubin after birth simply represents the withdrawal of the placenta and the large excretory capacity of the maternal liver.

The transplacental passage of reserpine may be of significance in the toxemic mother who is treated for hypertension with reserpine. The drug may cause a syndrome in the baby characterized sometimes by drowsiness but more commonly by an intractable stuffy nose. This tenacious nasal mucous may be enough to cause respiratory embarrassment, since newborns are obligate nose breathers.

Table 6 lists a group of substances which do not ordinarily pass the placenta. The fetal pituitary is active, and the normal development of certain of the target organs may in fact depend on fetal pituitary function. Growth hormone is an important exception. Apparently embryonic growth is independent of the necessity of growth hormone stimulation. Jost,[6] in rabbits, has decapitated embryos and returned them to the uterus to allow their continued development. Despite being totally headless, these rabbit embryos went to term and were normal in size. Exactly what factors control the growth of embryos is not known, but growth hormone itself appears not to be indispensable until considerably later.

Table 6

NOT PERMEABLE

Most proteins
TSH, ACTH
Growth Hormones
(Exception Insulin,
Immune Globulins)
Nucleic Acids
Neutral Fats
Phospholipids

The gamma globulins are an important class of proteins towards which selective permeability is demonstrated. Gamma-G, making up the larger part of the immunoglobulins, passes the placenta and is found in fetal blood in nearly the same concentration as in maternal blood. However, gamma-A and the large gamma-M globulins are nearly totally excluded. As a result, babies are born without a preformed library of gamma-M antibodies against the common gram negative organisms in their environment. Many workers feel that the peculiar susceptibility of newborns to infection by gram negative organisms results from the lack of this preformed antibody library rather than from the inability to form new antibody in response to a specific stimulus. In certain animal species, the fetal concentration of gamma globulins is even higher than the maternal concentration, and active transport is suspected.[4]

This selective permeability has implications also for erythroblastosis. The ABO antigens are probably more powerfully antigenic than the Rh antigens. We would therefore expect ABO erythroblastosis to be more devastating than Rh disease. The opposite finding appears to be on the basis of

placental permeability. Rh antibodies are frequently of the 7-S variety and pass the placenta relatively early and well. The ABO antibodies are often 19-S macroglobulins, and 7-S antibodies in response to ABO antigens are formed in lower titer.

Table 7

TERATOGENS

- Thalidomide
- Antimetabolites
  - Aminopterin
- Androgenic Steroids
- Corticosteroids (?)
- Quinine
- Antithyroid Drugs
- Radiation

Table 7 lists a group of potentially teratogenic substances. Thalidomide is so familiar I hesitate to enlarge upon it. Almost all antimetabolites cross the placenta reasonably well and are injurious to the fetus. They are frequently used as abortifacients, and if they are used in inadequate dosage so that the fetus is not destroyed, a terribly damaged infant may result. Quinine has also been used as an abortifacient and also is teratogenic. Androgenic steroids cause masculinization of female fetuses and may result in pseudohermaphroditism. Even progesterone and other estrogenic substances given in attempt to prevent threatened abortion may cause masculinization because of close structural relationship and partial cross specificity with the adrogenic steroids.

Table 8

DRUGS AFFECTING NEWBORNS

- Dicumarol
- Reserpine
- Hexamethonium
- Narcotics and Sedatives
- Inhalation Anaesthetics
- Diuril
- Streptomycin
- Narcotic Addiction

In Table 8 there is a list of drugs which pass the placenta and can cause injurious effects to the newborn. Some of these I have mentioned already. Dicumarol, even in normal dosage, may cause bleeding in the fetus and may even cause fatal hemorrhage. Hexamethonium may be used to treat maternal hypertension from toxemia. There have been instances of prolonged paralytic ileus in the newborn resulting from this drug. Occasionally such babies have been erroneously operated upon with a diagnosis of intestinal obstruction. The fact that narcotics and sedatives given to the mother may depress the baby is, I am sure, familiar to you all. The infant of a mother addicted to narcotics may demonstrate withdrawal symptoms in the newborn period. The baby's irritability, convulsions, and other neurological signs may be attributed to cerebral hemorrhage unless narcotic withdrawal is considered. Observation of the mother for withdrawal symptoms is a good way of confirming this diagnosis. The baby can be treated by using paregoric or some other substitute agent and withdrawing it slowly.

Table 9

G6PD HEMOLYSIS

- Vitamin K
- Naphthalene
- Furadantin
- Sulfonamides
- Phenacetin
- Aspirin
- Acetanilid
- Probenecid

Table 9 is a list of drugs which will cause hemolysis in a child with a genetic defect in glucose-6-phosphate dehydrogenase. This is significant in that 10% of Negroes, a sizeable percentage of Mediterranean peoples, and Sephardic Jews carry this genetic trait.

Table 10

PLACENTAL PATHOLOGY

- Single umbilical artery
- Monochorionic twins
- Velamentous insertion of cord
- Fetomaternal hemorrhage
- Placental insufficiency syndrome
  - toxemia
  - multiple pregnancy
  - "postmature"

Table 10 lists certain pathologic occurrences in the placenta which have important implications for the fetus. A single unbilical artery is seen in about 1% of single births and about 3% to 7% of

twins. In various series, between 10% and 50% of infants with single umbilical artery will have associated, often major, congenital malformations. Many of these malformations are easily recognized, but an intravenous pyelogram in search of a urinary tract anomaly may be well advised in such babies.

Another newly recognized syndrome is cross transfusion in monochorionic twins. One in every 60 to 80 births is a twin birth, and about ⅓ of these twins are one egg or identical twins. Identical twins can immediately be ruled out if the twins are of unlike sex. Of the identical twins, about ⅔ will have a single chorion, and all such twins have some degree of vascular anastomosis between the two fetuses. The single chorion is recognized by examining the common wall between the two amnionic sacs. If these two layers can be peeled apart easily and are thin and glistening, coming apart down to the placental surface where bare blood vessels are revealed, the twins are monochorionic. If the amnions come apart with difficulty and appear to have an additional layer of tissue in between, this is the double layer of chorion which surrounds each individual amnion in dichorionic twins.

The importance of performing these maneuvers and establishing that one is dealing with monochorionic twins is two-fold. In the first place, the monochorionic twin is a guaranteed identical twin, and is a walking tissue donor for his other twin. Working out the proof of identity by blood typing and skin grafting is a much more tedious affair. The second and more immediate significance is that one twin may give a significant blood transfusion to the other. This occurs when the anastomoses are from artery to vein, so that blood is pumped from a high pressure into a low pressure vascular bed. The plethoric twin is cyanotic, with enlarged heart and kidneys, increased blood volume, may be in frank congestive failure and tends to have polyhydramnois. This twin may need an emergency phlebotomy. The anemic twin may be smaller, look malnourished, and typically has oligohydramnios. Of the two, the plethoric twin is often in greater difficulty.

Abnormal insertions of the umbilical vessels predispose to fetal bleeding. In addition to gross hemorrhage such as is caused by rupture of a vessel entering the surface of the placenta, more minute hemorrhages occur very frequently. Fetal hemorrhage into the placenta is important from a number of standpoints. It may be of major proportions and result in exsanguination of the fetus. It may allow substantial amounts of fetal blood to enter the maternal circulation and hence predispose to erythroblastosis in the next pregnancy. Hemorrhage may be chronic and sufficient in amount to result in hypochromic anemia in the newborn. Finally, the child may be normal in every respect except for normocytic anemia already present at birth. This may be the result of a moderate sized acute hemorrhage. In cases where feto-maternal hemorrhage is suspected, a search can be made for fetal cells on a maternal blood smear by the use of buffer solutions which hemolize adult cells but leave fetal cells intact. If repeated examinations are made at intervals during pregnancy, 40% to 50% of women will be found to have some fetal blood in their circulations.

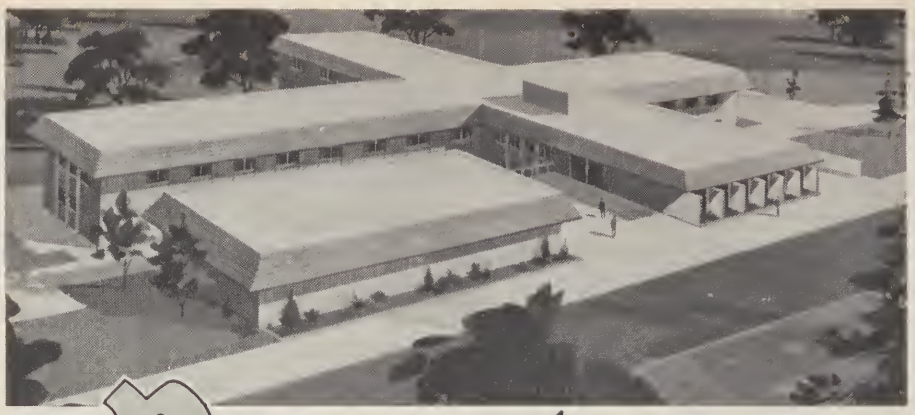
Finally, we have instances in which the placenta is inadequate. The babies resulting from placental insufficiency have been variously termed dysmature, small for dates, or cases of intrauterine malnutrition or growth failure. These babies are recognizable because their birth weight is significantly less than that expected for their gestational age. Placental insufficiency syndromes are seen most commonly after toxemia and multiple pregnancies. In one study,[7] toxemia was shown to reduce placental blood flow from 600 cc per minute to 200 cc per minute, thus potentially limiting the supply of both nutrients and blood gases for the fetus. It has been demonstrated that twins frequently cease significant growth after the 35th week of gestation, because the larger combined mass of the twins outstrips the potential of the placenta. Triplets and quadruplets outgrow their placenta proportionately earlier.

Table 11

PATHOLOGY CONTRASTED

pre-term	small for dates
RDS	hypoglycemia
Sepsis	stillbirth
Renal immaturity	meconium aspiration
feeding problem	sudden death
temp. regulation	small stature (?)
slow gain	catchup growth
jaundice	

Table 11 contrasts the small for dates baby with



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the true premature. The true premature is predisposed to respiratory distress syndrome, sepsis, organ immaturities such as poor kidney function, difficulty in taking adequate volumes of feeding, problems in temperature regulation, jaundice due to liver enzyme immaturity, and slow intitial weight gain. The small for dates baby has an increased incidence of stillbirth (apparently from outright placental failure), hypoglycemia, meconium aspiration syndrome and sudden unexpected death. The mortality of the small for dates baby is greater than that expected on the basis of gestational age, but less than that expected on the basis of birth weight. Many of the extremely small for dates babies are reduced in ultimate stature and in intelligence as well.

In summary, the placenta is the life support of the embryo and fetus. It insulates him from maternal immunologic rejection, secretes hormones necessary for the maintenance of pregnancy, allows for the removal of toxic metabolites, and supplies him with nutrients and blood gases needed for life and growth. The placenta itself goes through a definite development and senescence, and may become functionally inadequate before the child is born. In that case, varying degrees of wasting and injury to the fetus result. Many drugs adminstered to the mother will affect the fetus as well, often adversely. Certain pathologic conditions in the placenta itself may be correlated with conditions in the fetus. The placenta may, then, be an area where embryologist, obstetrician, and pediatrician may come together in the interest of better care for the baby.

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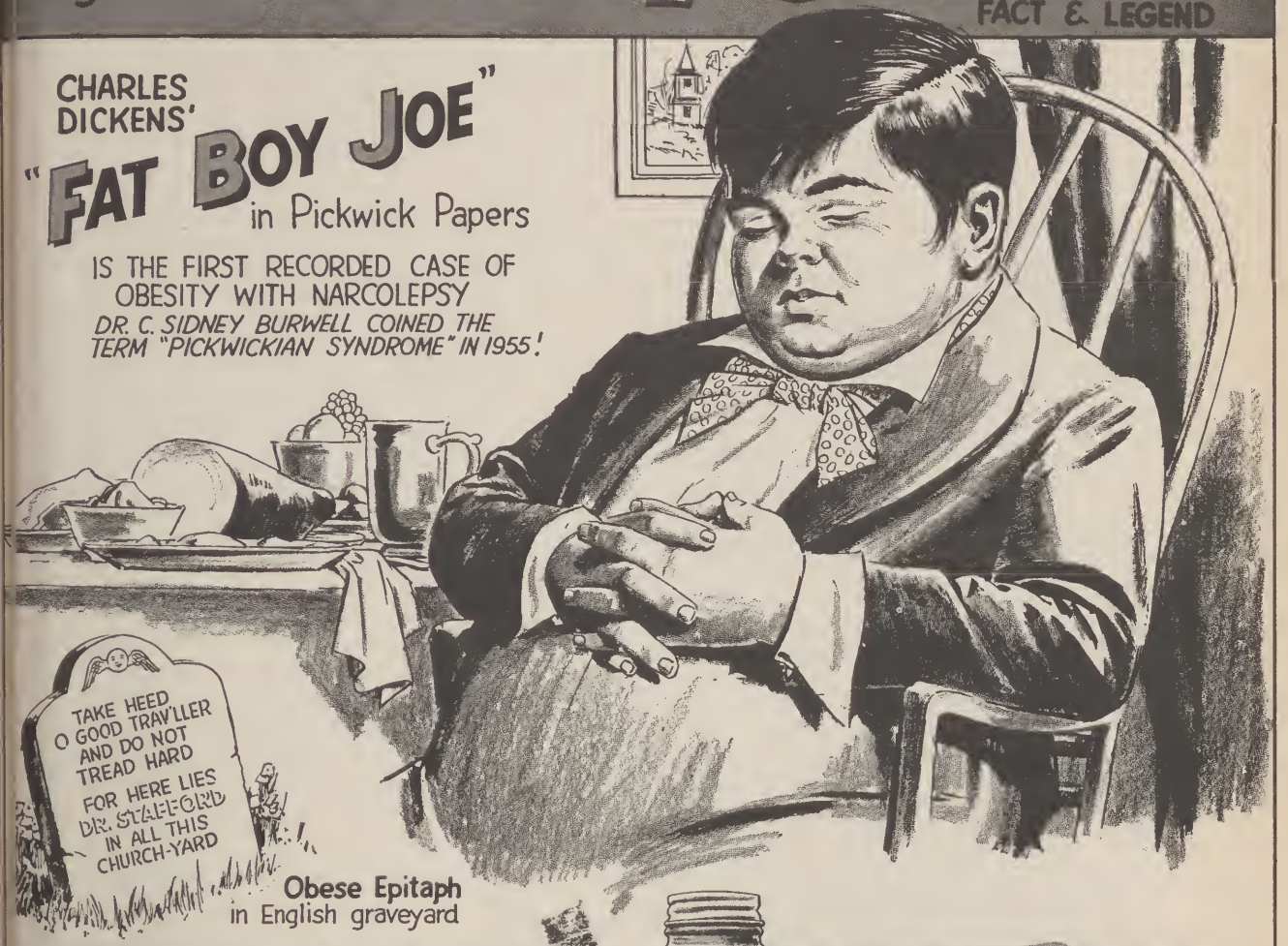
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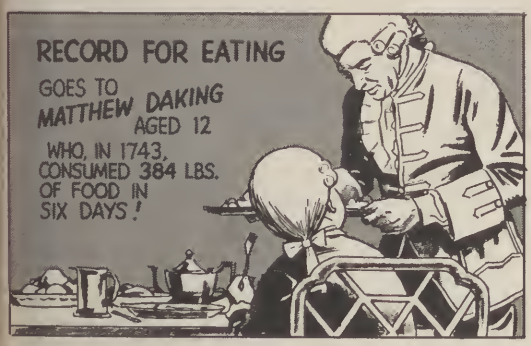
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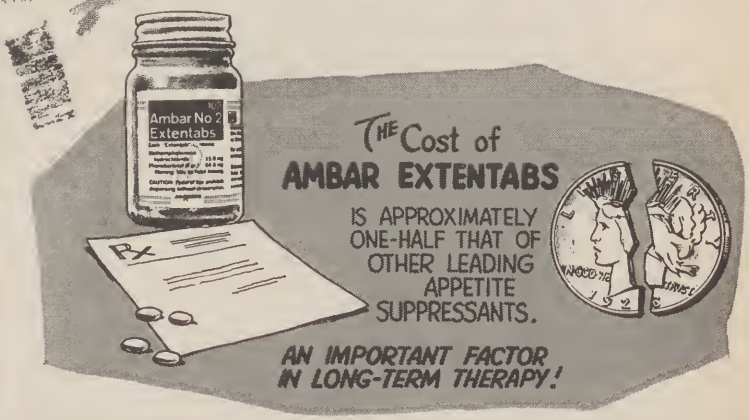
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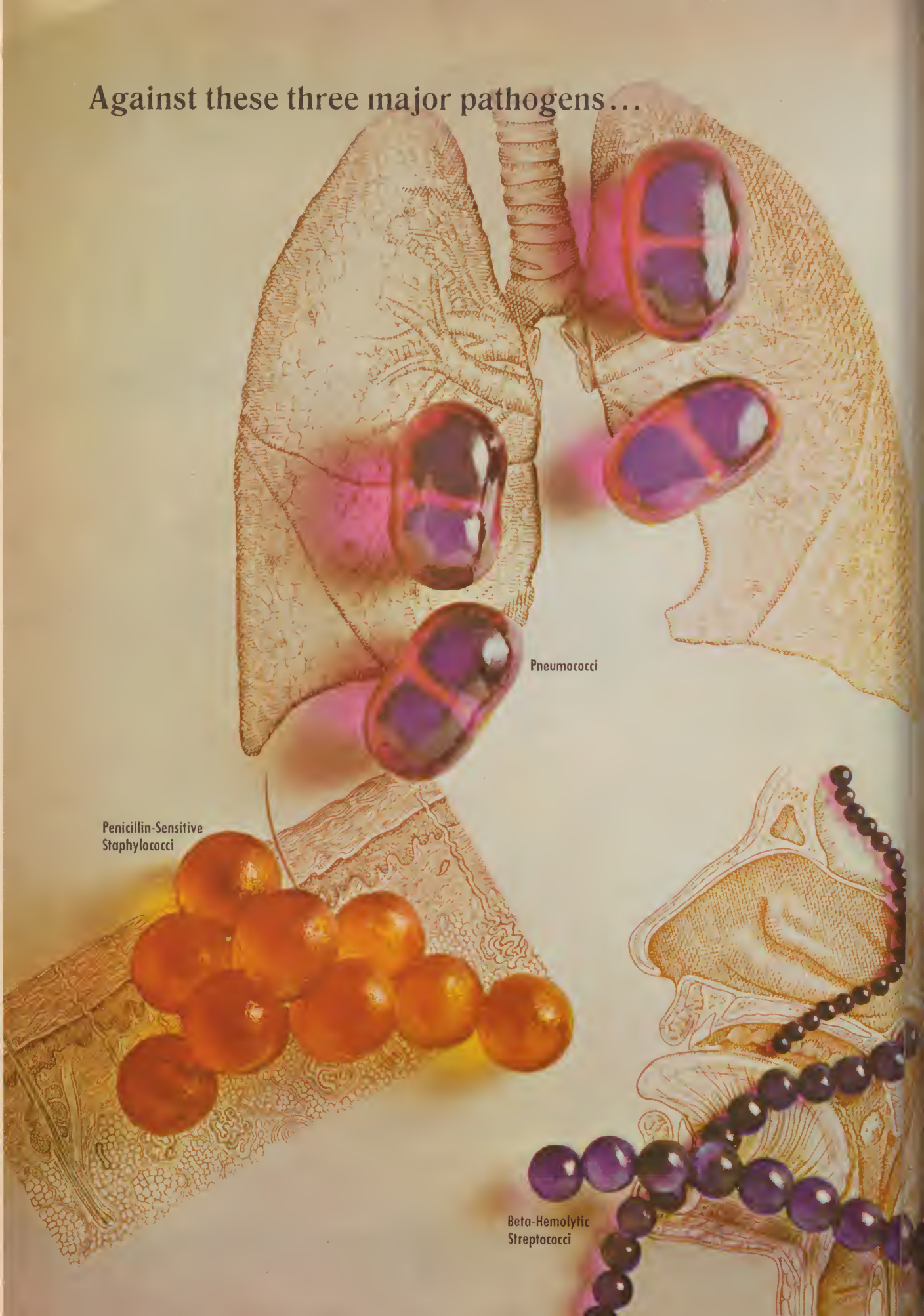
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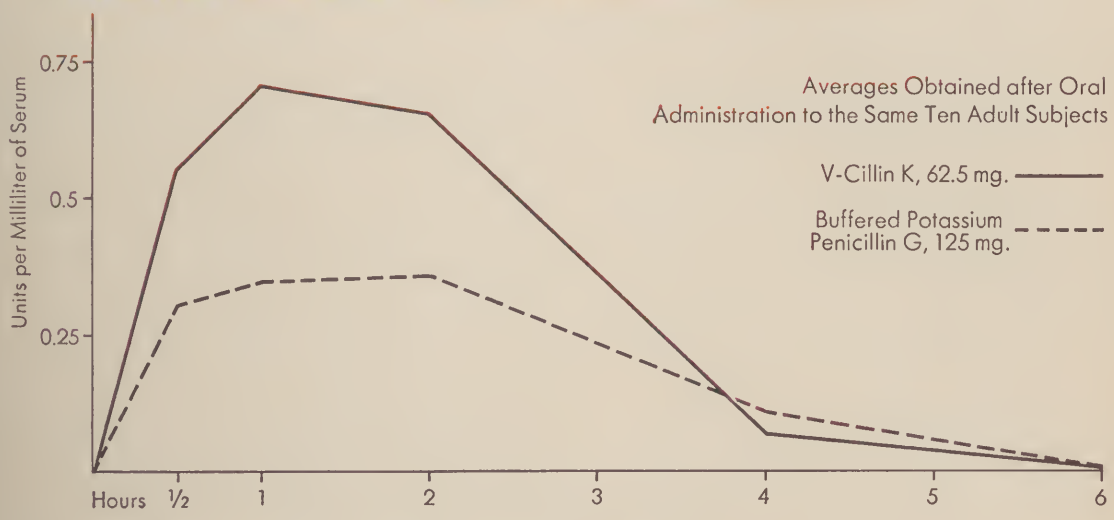
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Methicillin	1.6	0.4-6.3	0.2	0.1-0.4	0.2	0.1-1.6
Oxacillin	0.4	0.1-3.1	0.04	0.02-0.4	0.1	0.04-0.8
Cloxacillin	0.2	0.2-0.8	0.1	0.1-0.8	—	—
Nafcillin	0.4	0.2-0.8	0.04	0.02-0.1	0.02	0.02-0.2
Ampicillin	0.2	0.1-0.8	0.02	0.01-0.04	0.02	0.01-0.04

Adapted from Klein, J. O., and Finland, M.: New England J. Med., 269:1019, 1963.

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Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Warnings: In rare instances, the use of penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin and in those with bronchial asthma or other allergies. Resuscitative drugs should be readily available for emergency administration. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for relief of immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with g parenteral dosage schedules, frequent evaluation of the rena hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory st (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrow pencillin-insensitive organisms. In such cases, its administration s be discontinued, and appropriate measures should be taken.

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For gonorrhea in males, 500 mg. (800,000 units) every four hrs f three doses may be employed; in females, 500 mg. every four for six doses are recommended. Refractory infections generally re to a second treatment three to four days following completion first. Treatment of gonorrhea with severe complications shou individualized, with prolonged and intensive treatment. Patients suspected lesion of syphilis should have a dark-field examinat fore receiving penicillin and monthly serologic tests for a minim three months.

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REHABILITATION Notes

REHABILITATION SECTION
BALTIMORE CITY MEDICAL SOCIETY,

DOUGLAS G. CARROLL M.D.
EDITOR

The Hand in Rheumatoid Arthritis: Part II

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The Johns Hopkins University School of Medicine

DOUGLAS CARROLL, MD
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Baltimore City Hospitals

In a previous communication some selected deformities of the hands associated with rheumatoid arthritis were discussed and their surgical correction illustrated.

The following case report illustrates the use of reconstructive hand surgery in rheumatoid arthritis. The results of the Upper Extremity Function Test (UEFT) are included.

L.M. (BCH #385463)

Rheumatoid arthritis was diagnosed in this 53 year old white woman at age 8. Her life since has revolved around the progressive joint involvement and pain.

The first symptom, at age 5, was an inflamed swollen right knee. The arthritis migrated to the left knee, spine, hips, ankle, elbow and shoulder, but the symptoms were controlled with salicylates and no deformities resulted.

With the onset of her menstrual periods at 13, there was a reduction in all symptoms which continued until menopause at age 40. However, she was never entirely free of pain.

For the last 13 years she has become progressively worse with involvement of wrists, ankles, fingers and toes in addition to the aforementioned joints. Pain and morning stiffness, somewhat relieved as the day proceeds, has been constant. Weakness, fatigue, anorexia, malaise, and a low-grade fever have been intermittently present over the past 10 years. There has been recent pain and limitation in motion of the tempero-mandibular joint with difficulty in mastication.

She has visited numerous hospitals seeking relief. Seven years ago at the National Institute of Health a regimen of prednisone gave partial relief for several years. Two years ago she received triamcinolone for about 1 year. The steroid therapy caused her to gain weight to 128 lbs. with the typical Cushingoid facies, buffalo hump and protuberant abdomen. For the past 1½ years, she has received only Darvon and salicylates. Her weight has dropped to 90. Involvement of the hands and feet has progressed rapidly in the past 2 years. Ambulation is shuffling and difficult.

In 1959 she suffered a fracture of the left tibia and in August, 1963, a spiral fracture of the distal ⅓ of the left femur. Both of these accidents required prolonged bed rest.

In April 1963, a program for the surgical reconstruction of the patient's hands was begun and continued as listed in Figure 1.

Figures 2 to 5 show the appearance of hands in maximal finger extension before and after Vainio arthroplasty.

1. 1959—Fracture Left Tibia
2. April 6, 1963—Fusion right wrist
   Repair ruptured extensor tendons of right digits 3 and 4.
   Attached to extensor tendon of digit 2.
3. Aug. 18, 1963—Spiral fracture distal 1/3 left femur.
4. Nov. 22, 1963—UEFT Score Right 55 Left 16
5. Jan. 6, 1964—UEFT Score Right 63 Left 41
6. Jan. 30, 1964—Fusion MP joint Left Thumb.
7. June 6, 1964—UEFT Score Right 68 Left 31
8. June 29, 1964—Fusion IP joint Right Thumb.
9. Aug. 8, 1964—UEFT Score Right 53 Left 33
10. Sept. 14, 1964—Vainio Arthroplasty, MP Joints 2-5 on right.
11. Oct. 20, 1964—UEFT Score Right 62 Left 36
12. Nov. 19, 1964—Vainio Arthroplasty, MP Joints 2-4 on left.
13. Feb. 2, 1965—UEFT Score Right 67 Left 26
14. Feb. 4, 1965—Arthrodesis left wrist
15. April 7, 1965—UEFT Score Right 55 Left 22
16. Feb. 14, 1966—Open reduction and fixation for non-union fracture left femur
17. Oct. 17, 1966—UEFT Score Right 53 Left 34

Fig 1
Accidental Fractures, Reconstructive Surgery and UEFT Scores on the Hands of L.M.



Fig 2
6-17-64 Right hand maximal finger extension.



Fig 3
10-16-64 Maximal finger extension Right hand after arthroplasty MP joints 2-5.



Fig 4
6-17-64 Left hand, maximal finger extension.



Fig 5
1-14-65 Left hand maximal finger extension after arthroplasty MP joints 2-4.

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Figure 1. records serial studies of upper extremity function performed between 1959 and 1965 in relation to various surgical procedures. This upper extremity function test (UEFT) was developed in this department in an attempt to obtain a semiquantitative evaluation of hand function in a wide variety of hand impairments. Although the results are repeatable in stable traumatic and neurological impairments, they vary in patients with rheumatoid arthritis depending on the amount of pain present. If performed when the patient has no pain in the upper extremity, the scores are consistent. Figure 1 demonstrates that there has been no significant change in hand function with the various surgical procedures performed.

The cosmetic appearance of the hands has improved, and it is believed that the surgery will prevent or delay further deterioration of hand function.

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1. Clark, G. L, Jr. and Carroll, D. *The Hand in Rheumatoid Arthritis*: Part 1. Maryland State Med J (May) 1967.
2. Carroll, D. *An Upper Extremity Function Test.* Maryland State Med J (February) 1967.



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STATE OF MARYLAND

Department of Mental Hygiene

Isadore Tuerk, MD, Commissioner

Kurt Gorwitz, ScD, Statistics Director

Mortality Among Alcoholics

A total of 6,853 patients with a primary diagnosis of alcoholism were treated in Maryland's public and private inpatient and outpatient facilities in the three year period from July 1, 1961 to June 30, 1964. In addition, 1,969 individuals with other diagnoses were reported to have a drinking problem. Of these 6,853, 351 (or 5.1 percent) are known to have died while under care or after release by June 30, 1964. The following table, based on data from the Maryland Psychiatric Case Register, shows the distribution of these deaths by age at death and by cause.

		Age at Death (Years)				
Reported Cause of Death	Total	25-34	35-44	45-54	55-64	65 and Over
Heart Disease	101	2	7	33	29	30
Cirrhosis of Liver	46	5	18	14	7	2
Accidents	33	2	8	17	5	1
Cancer	30	—	4	9	12	5
Pneumonia & Bronchitis	29	2	7	10	5	5
Alcoholism	16	1	4	7	4	—
Vascular Lesions	12	—	2	5	1	4
Suicide	11	1	2	3	3	2
Tuberculosis	9	—	1	7	—	1
All Others	64	10	13	21	9	11
Total	351	23	66	126	75	61
Alcoholics Under Care During Period	6,853*	1,181	2,364	2,022	904	197
Percent Known to Have Died	5.1%	1.9%	2.8%	6.2%	8.3%	31.0%

*185 Alcoholics Were Less Than 25 Years of Age

As in the general population, heart disease was the most important cause of mortality, accounting for nearly 30 percent of all deaths. Thirteen percent were reported as due to cirrhosis of liver, the second most frequent cause. By comparison, 1.4 percent of all Maryland deaths during this time period were from this cause. Only four percent of all deaths from cirrhosis of the liver had been under treatment in a psychiatric facility during this three year period. Proportionally, accidents, pneumonia and bronchitis, alcoholism, suicide and tuberculosis were also more frequently reported as the cause of death among alcoholics

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than in the general population while cancer and vascular lesions occurred less often. However, only 21 of the 165 Maryland deaths from alcoholism had been reported to the Case Register as under care in a reporting facility. Of these 21, 16 had been diagnosed as alcoholics.

Nearly one-third of the alcoholics, 65 years or older, were dead at the end of this observation period. High rates were also indicated in all other age groups. Although these can not be strictly considered age-specific mortality rates, since the time between admission and death was not computed, they are substantially higher than similar rates for the total Maryland population. They indicate that major physical illnesses are a frequent occurrence among these alcoholics.

TOWARD A NEW LIFE FOR OUR DISABLED

SHERMAN LAZARUS
Project Director, Comprehensive Statewide Planning for the Vocational Rehabilitation of Maryland's Handicapped Citizens

With the passage of the Vocational Rehabilitation Act of 1965, tremendous opportunities opened up for venturing beyond traditional rehabilitation lines in reaching and serving greater proportions of the physically and mentally handicapped citizens of our State. The restoration of increasing numbers of individuals to useful, productive living through gainful employment and/or participation in family and community activities requires that rehabiliation efforts be focused not only upon those with comparatively static disabling conditions but also upon those with progressive disabling conditions (eg, multiple sclerosis, muscular dystrophy) and other groups—including those disabled by cancer, stroke, and even the disabled law offender. Comprehensive Statewide Planning encompasses this objective of raising the scale of the State's rehabilitation program so that all of the State's disabled can be served as soon as possible but not later than 1975.

The achievement of this objective is dependent upon the availability of the necessary financing, facilities, and trained manpower. It is also dependent upon greater fusion of public and private rehabilitation efforts. In this connection, Mary E. Switzer, Commissioner of Vocational Rehabilitation, remarked that "One of the great tests of the next ten years will be to see whether, when the developmental state of rehabilitation in the United States gives way to a massive attack upon disability among our people, the rehabilitation movement can merge group interest into a truly cooperative national effort."

In order that we may serve increasing numbers of our handicapped population, we need to look at ways for improving the quality of services provided to our disabled. This means that we must continually search for and organize new patterns and organizational approaches for providing these services. For example, are we rehabilitating our disabled to their maximum level or potential? Are we involving the family of the disabled in the rehabilitation process? Are services organized so as to meet the needs of the disabled or are they organized along traditional agency lines?

What of the developing role of the workshop in vocational rehabilitation? During the Congressional hearings which accompanied the consideration of the 1965 Amendments, the need for achieving quality improvement of existing workshops as well as for constructing badly needed new workshops was underscored. Since workshops represent a valuable clinical tool—in terms of diagnosis, evaluation, and training—and also function as a transitional and long-term employment opportunity for many disabled persons, it is paramount that adequate workshop standards be developed. We also need to address ourselves to problems experienced by existing workshops in obtaining sub-contracts, in pricing proposals, etc. We might also want to consider the merits of establishing satellite workshops (eg, in nursing homes, sparsely populated areas).

How can we ensure the availability of sufficient numbers of trained manpower? We need to re-examine salary scales, recruitment practices, patterns of utilization of personnel, training practices, etc. Emphasis must, of course, be upon the maximum possible uses of our scarce human resources.

In summary, we have an opportunity through this Statewide planning effort to do something constructive about the needs of Maryland's handicapped citizenry. Although the task which lies before us is well within our grasp, it will take a coordinated and concentrated effort—on the part of all of us who care about providing our citizens with the prospect of a new life—if we are to succeed.

Alcoholism SECTION

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

Provident Hospital's Acute Alcoholic Detoxification Unit

PROGRESS REPORT

Roland T. Smoot, MD, Addison W. Pope, MD, and John H. Weber

On April 17, 1967, Provident Hospital opened a five bed Alcoholic Detoxification Unit, the first of its kind in the Greater Baltimore area. The new service, limited and experimental, is in accordance with current medical and legal decisions that alcoholics are a medical rather than a correctional responsibility.

The Unit is under the supervision of the Hospital's Department of Medicine, of which Roland T. Smoot, MD, is chief. Consultation has been made available by Addison W. Pope, MD, Regional Mental Health Director for Baltimore City, and Charles R. Venter, MD, Director of the Crownsville State Hospital Alcoholic Rehabilitation Unit. John H. Weber is alcoholism counselor, and five recovering alcoholics serve as orderlies. Training programs for medical and nursing staff were provided by the Department of Mental Hygiene.

The statistical report on the Unit's first month of operation reveals that 20 patients were admitted and treated during that initial period: 16 male, 4 female; 12 Caucasian, 8 Negro; 10 covered by Medical Aid, 8 by Blue Cross-Blue Shield, and two by private means; 8 were referred by Alcoholics Anonymous, 6 by hospital staff physicians, two by the Baltimore City Health Department Alcoholism Clinic, two by other general hospitals, one by Baltimore Area Council on Alcoholism, and one by Provident Hospital Outpatient Clinic; 14 were referred to Alcoholics Anonymous for follow-up service, three to the Baltimore City Health Department Alcoholism Clinic, and three to Provident Hospital Outpatient Clinic.

The average length of stay for the 20 patients was 4½ days.

During the month, 19 additional alcoholic patients applied for treatment but were not admitted to the Unit: 8 could not be accommodated because of lack of beds, 4 were referred to more appropriate agencies, 3 changed their minds, and 4 had other problems which made admission inadvisable.

Dr. Smoot reports that problems anticipated in the management of acutely intoxicated alcoholic patients failed to develop. Because treatment was specific for acute alcoholism, complications generally experienced in withdrawal were avoided. Medical and nursing personnel now take for granted that these patients will present no more

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problems than other sick people.

Henry J. Whyte, Provident Administrator, regards the Unit as evidence of the Hospital's determination to serve the needs of the community, and plans expansion of this particular service in the new hospital now under construction.

TREATMENT

Treatment in the Alcoholic Detoxification Unit is directed toward alleviating or minimizing agitation and mental confusion that usually ensue with cessation of alcohol intake, and aiding in restoration of the normal metabolic processes of the body by correcting the nutritional, fluid and electrolyte and vitamin deficiencies that have developed.

Routinely the patients in this Unit receive 25 mg. of Librium (chlordiazepoxide hydrochloride) four times a day, with supplements of 100 mg. of Librium IM q 3-4 H as the state of agitation warrants; in extreme cases the use of paraldehyde (paracetaldehyde) may be necessary. Thiamin (vitamin B_1) in dosage of 100 mg. three times a day, in addition to multi-vitamins are given, along with antacids to reduce the gastric upset that is usually present. Fluids per os, mainly fruit juices, are encouraged so that at least 2500-3000 cc are ingested daily. Initially the patient is given a soft diet which is changed to a regular diet as soon as he or she is able to tolerate it. All acute withdrawal symptoms have usually disappeared within 72 to 96 hours, and the average stay in this Unit has been 4 to 5 days.

A psychiatric evaluation is usually obtained after the patient's mental faculties have improved sufficiently. This is usually obtained on the 4th or 5th day of hospitalization. Many patients are referred to one of the alcoholic clinics upon discharge where psychotherapy, if deemed necessary, is initiated.

Upon admission to the Alcoholic Detoxification Unit, each patient receives a complete physical examination and laboratory tests, including chest x-ray and screening blood urine tests to rule out evidence of infection and to assess liver and kidney function. Should these examinations reveal any abnormalities further studies and treatment are rendered as is warranted.



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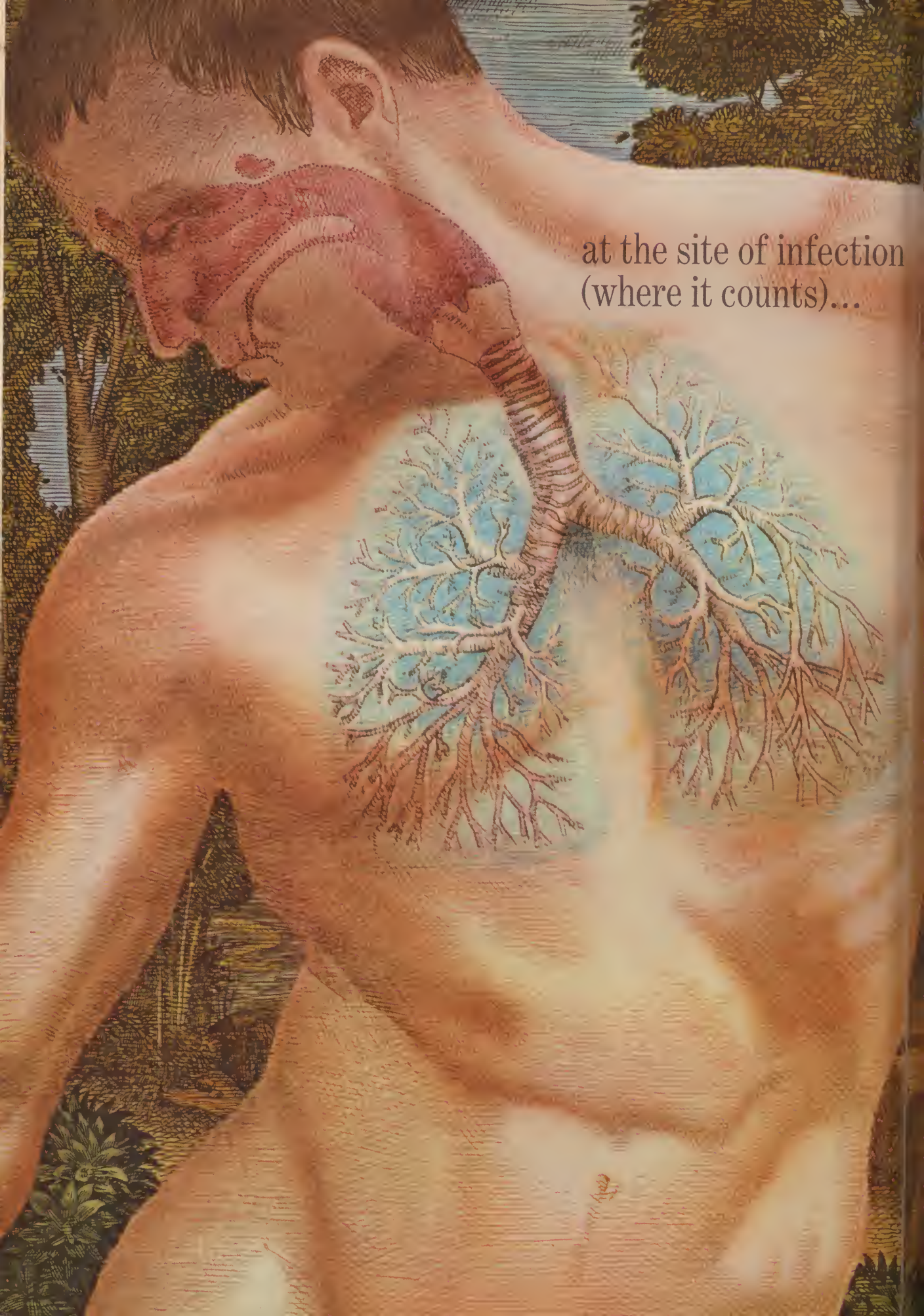
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In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

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Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with pre-existing liver disease or dysfunction.

Side-Effects: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have appeared in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly if the drug is readministered to sensitive patients, usually within forty-eight hours. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appeared to be definitely related to use of the drug, laboratory findings characterized by increased direct-reacting bilirubin, elevated alkaline phosphatase levels, negative or weakly positive cephalin flocculation and thymol turbidity tests, elevated serum glutamic oxalacetic transaminase levels, peripheral eosinophilia, and abnormal cholecystograms.

Individual idiosyncrasy seems evident since jaundice has been reported in other patients taking prolonged courses of the medication. Patients with chronic infection have been given up to 2 Gm. of the drug daily for periods of two to six months, and patients with rheumatic fever have taken prophylactic doses of 0.5 Gm. daily for two years without difficulty. In one group of 144 patients who received the drug daily for two years, no jaundice was noted. It was of interest that members of six of these patients' families, who were not taking the drug, had episodes of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels were determined in a group of fifty-four adults and children who took 250 mg. of Ilosone daily for an average of sixteen months as rheumatic fever prophylaxis. The results were compared with those of a similar group of forty-four patients who received penicillin. There were no cases of jaundice in either group. Elevations of SGPT and serum alkaline phosphatase levels during the course of treatment was observed in one patient treated with Ilosone and in two patients treated with penicillin. Seven other patients in the group receiving Ilosone and four others in the penicillin group showed elevations in one of the tests at some time during administration of the drugs.

Very satisfactory therapeutic results, without toxicity, were reported in 102 pediatric patients who received short-term (ten day) courses of Ilosone in the treatment of streptococcus infections. Results of liver function tests in these patients were comparable to those in a similar control group who had received penicillin.

Gastro-intestinal disturbances not associated with hepatic effects are observed in a small proportion of individuals as a result of a local stimulating effect of the medication on the alimentary tract; however, the normal intestinal gram-negative bacterial flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with this type of erythromycin, there have been occasional reports of urticaria, skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orally.

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For infants and for children under twenty-five pounds of body weight, the usual dosage is 5 mg. per pound every six hours; for children twenty-five to fifty pounds, 125 mg. every six hrs. (Tablets Ilosone Chewable should be chewed or crushed and swallowed with water.)

For adults and for children over fifty pounds, the usual dosage of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythromycin therapy should be considered.

In the treatment of syphilis, the recommended total dose is 20 to 30 Gm. given in divided doses for a period of ten to fifteen days. Close follow-up of the patient is necessary since erythromycin drugs have not had adequate evaluation in all stages of syphilis. Examinations of spinal fluid are recommended as part of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four days are recommended. In the treatment of gonorrhea, patients with a suspected lesion of syphilis should have a dark-field examination before receiving antibiotics, and monthly serologic tests should be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and 250 mg. (equivalent to base), in bottles of 24 and 100.

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Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equivalent to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size packages.

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2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:39[illegible].
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MARYLAND ASSOCIATION OF MEDICAL ASSISTANTS

JUNE, 1967

Baltimore Chapter Holds Dinner

On Tuesday, May 9th, the BAMA held their annual "Bosses' Night." Approximately 75 persons attended the function. Special guests were: Drs. R. Atkins, L. Berger, E. Berstock, A. Cole, E. Cumerma, R. Fisher, A. Himelfarbe, D. Jovanovski, E. Lisansky, J. Littleton, M. Trail, H. Wollenweber, J. Willis, and T. Wilson. Also present were W. E. Tucker, Physical Therapist at Church Home and Hospital, and T. G. Whedbee, Director of Church Home and Hospital. Cocktails and dinner were served in the York Room of the Penn Hotel in Towson.

After dinner "Dolly Awards" were presented to each Doctor commending him for his special interest or talent. These awards consisted of a small doll sprayed gold, taped to a bottle of Jim Beam Bourbon covered in gold paper. To further augment their appreciation of their bosses, and his special talent or hobby, each physician was presented with a small gift.

This gala event closed with the presentation of "Disaster" or "How Dr. Egghead's Office Ceased to Function Without his Medical Assistant" by the BAMA Thespians. The cast members were:

Miss Bacon: Elva Edmondston, Dr. Egghead: Dorothy Hartel, The Penguin: John Komber, Batman: William Leiby, Robin: Peggy Bury.
As requested, the audience participated in the production by applauding and hissing on cue.

During the evening certificates were presented to those who had attended the Anatomy and Physiology Course. Melvin Trail, MD, of Church Home and Hospital presented these in behalf of Jack Zimmerman, MD, who was unable to attend.

A special thanks for "Bosses' Night" goes to Dolly Stuck, Chairman of Arrangement Committee; the BAMA Thespians; and the "Bosses" and Medical Assistants who attended.

ALLEGANY COUNTY

On Wednesday, April 26, 1967 the Allegany County Medical Assistants Association held their monthly dinner meeting at the Ali Ghan Country Club. Following the dinner, Gina Glick, MD, head of the Anesthesiology Department at Sacred Heart Hospital, Cumberland, gave a very informative and interesting talk on Anesthesiology. Other highlights of the meeting were the distribution of *AAMA* pins and a report on the State Meeting by Mrs. Gertrude Gillum, President-Elect, *MAMA*. Election of officers will be held at the May meeting.

WICOMICO COUNTY

The May meeting of the Wicomico Association of Medical Assistants was held on May 10th at the Peninsula General Hospital School of Nursing Auditorium. Speaker of the month was Rolf Emberland, MD, a Biochemist, from Peninsula General Hospital, whose topic was entitled "Hormonal Balance in the Pregnant and Non-Pregnant Female." Dr. Emberland was born and raised in Norway, and educated at the University of Copenhagen. He came to the United States in 1960, where he worked at the Worcester Foundation for

Experimental Biology, in Massachusetts, in research on hormones. It is interesting to note that he worked under Gregory Pincus, MD, a famous figure at the institute, who was the first founder of the birth control pill. Dr. Emberland joined Peninsula General Hospital in 1962.

The Wicomico chapter is at work on the Seminar, which is to be held in Salisbury this year. The theme will be Mental Health.

AAMA ANNOUNCES MEDICAL ASSISTANT SCHOLARSHIPS

The following news release has been received from the AAMA:

Chicago: Loans for medical assistant training are now available from the *Maxine Williams Scholarship Fund*, sponsored by the American Association of Medical Assistants.

Each loan is for $300. As AAMA assumes all administrative costs, there is no interest rate. Repayment may be made after the student is employed.

Anyone who is a high school graduate, and wishes to take formal training is eligible to apply for a loan. Application blanks are available from AAMA headquarters, 510 N. Dearborn St., Chicago, 60610.

The fund, named in honor of AAMA's first president, is supported entirely by private contributions. It was established to encourage those wishing to become medical assistants to take formal training, preferably at a school which offers a two-year course."

COMMITTEE CHAIRMEN APPOINTED FOR APRIL 1967-1968

The following Committee Chairmen have been appointed: Arrangements, Catherine Kousouris, Budget and Finance, John Komber; Civil Defense, Dorothy Walker, Constitution and By-Laws, William Leiby; Convention, Dorothy Hartel, Education, John Komber; Historian, Peggy Bury; Legislative, Dorothy Hartel; Membership, Frances Fairley; Membership Extension, Dorothy Hartel; Parliamentarian, Mary Rachuba; Program, Carol Davis; Program Printing, Ann Schultz; Publicity and Public Relations, Arlene Whalen; Registration, Margaret Krize.

These chairmen will pick their own committee members and will be contacting members throughout the state for assistance.

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Resolutions . . .

All resolutions to be presented to the House of Delegates at its meeting on **Friday, September 8, 1967,** must be in the Faculty Office, 1211 Cathedral St., Baltimore, Maryland 21201, no later than Friday, **July 14, 1967.**

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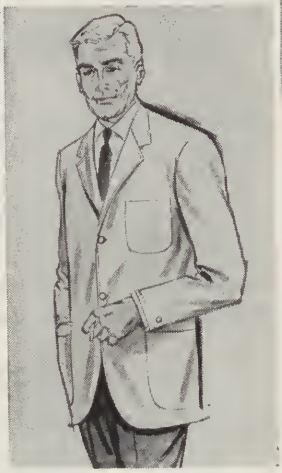
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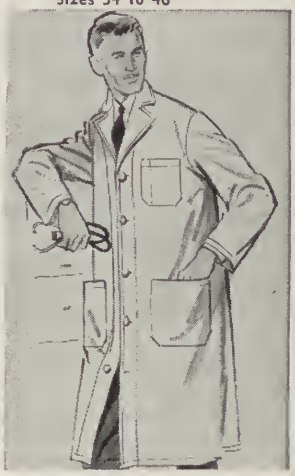
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HOSPITAL EXPENSES INCREASE

Higher wages and more personnel have resulted in an increase of $5.31 in total hospital expense per patient day in January 1967 as compared to the same month in 1966, according to figures in Hospital Indicators released on April 16 by the American Hospital Association.

In January 1966 a hospital's cost of caring for a patient for one day was $45.55; a year later this cost increased to $50.86.

Hospital Indicators, published monthly by *HOSPITALS*, Journal of the American Hospital Association, is based on data from a sample of 628 community hospitals taken from a universe of 5,736 hospitals registered by the AHA.

Payroll expenses account for about two-thirds of the hospital's operating costs. In January 1966 hospital payroll expense per patient day totaled $28.01; in January 1967 this expense category totaled $31.54.

The AHA survey also showed an increase of more than 80,000 full-time hospital personnel in the 12-month period. Hospitals reported 1,251,453 employed in January 1966 and 1,332,328 in January of this year. Part-time personnel increased from 296,995 in 1966 to 334,772 in January 1967.

the HEART PAGE

A Service of The Heart Association of Maryland

Elijah Saunders, MD—*Editor*

Transient Ischemic Attacks of the Brain: Part II—Management

On the Heart Page in the previous issue, certain diagnostic features of *transient ischemic attacks* were briefly noted, the importance of historical features emphasized and some of the conditions commonly confused with TIAs were mentioned. Once the diagnosis of TIA has been established, largely on historical grounds, attention is appropriately directed toward determining the cause of the ischemic episodes and prescribing therapy.

Blood studies to rule out either polycythemia or anemia are in order, since either can produce cerebral ischemia which may be transient. A normal chest x-ray and EKG help to vindicate the heart as being of etiologic significance. Particularly if symptoms follow head turning, cervical spine x-rays should be done since spondylosis or anomalies can diminish vertebral blood flow. A pulse lag and a 20 mm. systolic pressure difference in the two arms indicate obstruction in the innominate or subclavian vessels producing a "subclavian steal syndrome." Repeated pressure determinations in different positions may corroborate postural hypotension. Carotid sinus massage should not be done routinely because of the danger of embolization from a plaque at the bifurcation. An EEG, while not diagnostic, often if valuable in cases where epilepsy is a possibility and clear localization is not apparent from the history; further, the EEG, like the brain scan is a useful and harmless procedure in atypical cases where a mass lesion remains in the differential diagnosis. A lumbar puncture is appropriate in atypical cases especially when the possibility of meningovascular lues exists and, in any case, is required before anticoagulant therapy can be initiated. In a minority of cases, clinical examination or laboratory studies will provide a specific etiology and dictate a specific therapy, eg, elastic stockings for the patient with postural hypotension; a collar for the patient with spondylosis and ischemia on head turning; phlebotomy for the patient with polycythemia, etc. More often, the specific basis for the TIA is less obvious and is considered to be on the basis of degenerative vascular disease with the cerebral symptoms related to thrombosis or embolism. If the patient is experiencing TIAs and is hypertensive, gradual lowering of the blood pressure toward a diastolic pressure of 100 mm. is advisable, although the possibility of iatrogenic strokes keeps one cautious. Should a surgically correctable lesion that correlates with the patient's symptoms be found and if the patient's general condition allows for consideration of surgery, angiography is appropriate. Because of the possibility of dislodging embolic material from a plaque and the usefulness of knowing the condition of all vessels preoperatively, direct carotid

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puncture is being supplanted by four-vessel angiography via brachial or femoral catherterization.

When symptomatic "subclavian steal syndrome" is present, surgical intervention is in order. Similarly, a unilateral obstruction in the right internal carotid at the bifurcation producing transient right eye blindness and hemiparesis needs surgery. Unfortunately, such cases are infrequent; more often angiography is negative or inconclusive. In such cases, anticoagulation therapy should be considered, provided: (1) there is no history of hemorrhagic diasthesis, ulcer, or G.I. bleeding, (2) the patient is reliable, (3) the physician is acquainted with this type of therapy and a good laboratory is available for regular prothrombin determinations, (4) there is no evidence of bleeding into the subarachnoid space. Hypertension is, at least, a relative contraindication to anticoagulation. There is no unanimity of opinion as to the optimum time to continue anticoagulation; however, there is increasing evidence to support long range therapy lasting months to years.

Available evidence shows that prognosis is significantly better for posterior than anterior system insufficiency.

Stellate ganglion blocks and fibrinolytic agents have not proven of value. While 5% CO_2 in O_2 is a potent stimulus to increase blood flow, it is uncertain whether it is of practical value in TIA therapy. Determination of the usefulness of intravenous vasodilators and low molecular weight "Dextran" is currently under investigation.

In summary, the diagnosis of *transient ischemic attacks* of the brain can be made in most cases on the basis of the history alone; some cases can be further studied with simple office and laboratory procedures and the specific cause elucidated; others require special investigations including angiography before the most appropriate management can be instituted. TIAs are a treatable condition.

ERLAND NELSON, MD, PhD
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HIGHLIGHTS

PROMOTION OF ADEQUATE IMMUNIZATION

A follow-up program designed to encourage complete immunizations for all infants born in Maryland counties began in April. Following the routine birth registration notice, parents of newborns will receive communications from the Health Department urging that the baby be taken to a physician or health clinic for the recommended series.

Each letter contains a postage-paid card on which the parents are to indicate the baby's age and the date when the series was begun. The card is then to be mailed back to the Health Department. When the parents report that the basic immunization series has been completed, a permanent immunization record card will be issued. A similar program is in operation in many other states and in Baltimore City.

In addition to serving as a reminder to parents of the importance of early immunizations and boosters, the reply cards will help physicians and, State and local health departments to plan improved immunization services for the children in Maryland.

The birth certificate follow-up program is a phase of the Maryland Immunization Project being conducted by the Division of Communicable Diseases.

MARYLAND CHOSEN FOR FDA DRUG ABUSE CONTROL PROGRAM

Active negotiations by the Division of Drug Control have been instrumental in Maryland's selection by the Food and Drug Administration as one of eighteen states to join a cooperative Federal-State program to control the illegal distribution of prescription drugs. The Health Department has been designated as the enforcement agency for the State, dealing with violations on the drug store level, while the FDA concentrates on large scale operations. Selection was made on the basis of the State's potential, capability, and willingness to participate.

Personnel from other selected states in the region will join Department staff members in a three-day training course in Baltimore in June. In addition to enforcement procedures, the course will cover provisions of the 1965 Drug Abuse Control amendments, which apply to amphetamines, barbiturates, and other drugs found to have a potential for abuse because of their stimulant, depressant, or hallucinogenic effects.

PKU PROGRAM BEING EVALUATED

Procedures relating to the PKU program are being examined and evaluated by six subcommittees of the Advisory Committee on Hereditary and Metabolic Diseases, which serves in an advisory capacity to the Division of Community Services for the Mentally Retarded. Subcommittee findings on psychological follow-up, laboratory procedures, public health nursing, diagnosis, nutrition, and legislation and regulations will provide bases for Advisory Committee recommen-

dations to hospitals, aimed at clarifying current legislation and suggesting ways of simplifying implementation of the law. Physicians or hospitals may refer questions or specific problems to the Committee for study.

MARYLAND'S PUBLIC HEALTH PROGRAMS IN ACTION

A graduate course, *Maryland's Public Health Programs in Action,* jointly sponsored by Towson State College and the State Health Department, is scheduled from June 19 through July 10, 1967, in Osler Hall, Medical and Chirurgical Faculty Building.

ROSEWOOD PRE-ADMISSION PILOT PROGRAM

Starting May 1, a pilot program will be initiated through the Health Departments in five counties, designed to provide coordinated, cooperative, comprehensive community services to Rosewood State Hospital patients and their families, beginning when request for admission is made and continuing through pre-discharge and post-discharge phases. Administrative, medical, nursing, and social service staffs of the hospital and the Health Department's Divisions of Community Services for the Mentally Retarded and Public Health Nursing have developed guidelines and pre-admission forms. The program will be followed for six months before being recommended for statewide use.

IN-SERVICE TRAINING INSTITUTE HELD

Instructors from Maryland day care centers for the mentally retarded recently attended the Tenth Semi-Annual In-Service Training Institute held by the Health Department's Division of Community Services for the Mentally Retarded, at which basic principles and training techniques were taught. The formal two-week training course emphasizing problems of severe retardation was followed by a third week devoted solely to practical teaching experience.

Broadening of the day care concept since the first Institute in 1962 is reflected in the growth of the faculty from 8 to its present staff of 22 instructors and lecturers from the field of pediatrics, psychology, public health nursing, nutrition, speech pathology, occupational therapy, physical therapy, social work, and health education.

NEW ANIMAL CARE LAWS OUTGROWTH OF STUDY

A study of existing animal care laws, requested by Senate Resolution No. 22 of 1966, was performed by representatives of humane organizations and bio-medical research institutions, under chairmanship of the Chief of the Department's Division of Veterinary Medicine. As a result of its cooperative study, the committee drafted six bills, of which three were enacted by the 1967 General Assembly.

SALMONELLOSIS IN BABY CHICKS SUBJECT OF STUDY

In a two-week period during the Easter season, eighteen groups of chicks and ducks were collected by five county health departments and tested by the Bureau of Laboratories' Enteric Infection Section for the presence of salmonella organisms. Approximately 66 per cent were found to be infected with one or more of the five serotypes of salmonella. Following the study, the General Assembly enacted legislation prohibiting the sale of bady chicks and ducks as household pets.

PUBLIC INTEREST IN HEALTH EDUCATION LITERATURE

A recent evaluation of the State Health Department's service to public and school librarians revealed greatly increased interest in air pollution, water pollution, venereal disease, drug abuse, family planning, sex education, and cigarette smoking. The special service to librarians was inaugurated in 1966, in cooperation with the State Department of Education, in order to help make health educational materials more available generally. The collection now includes approximately 3000 volumes on medical, health, and related topics.



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Alcoholic Detoxification Unit at Provident Hospital

Baltimore physicians will be interested in learning that an Acute Alcoholic Detoxification Unit has been established at Provident Hospital, 1514 Division Street, Baltimore, Maryland 21217. The Unit, consisting of five beds, provides appropriate medical treatment for patients who are acutely intoxicated or those who are chronic alcoholics desiring treatment. In establishing this Unit, Provident Hospital has recognized the need of the modern hospital to provide care and facilities for the "whole patient" and not just segments of his illness. The unit will also serve not only as a place where interns, residents, nurses, attendants and orderlies can learn the signs and symptoms of acute alcoholic intoxification and the proper medical and nursing treatment techniques, but will also serve for research into the various treatment methods.

Procedures established by the Detoxification Unit are as follows:

1. Initially, patients will be admitted to the Detoxification Unit on an "Elective Basis" only.
2. Referral For Admission:
   a. Patients with the proper hospitalization insurance may be referred for admission as follows:
      1. By Physician Referral
      2. By Alcoholics Anonymous.
      3. By Members of the Clergy through the Alcoholism Unit Counselor.
      4. By Public Health Nurses through the Alcoholism Unit Counselor.
      5. Patients may be referred to the Detoxification Unit from any "In House" Service by the Attending Physician with the endorsement of the Chief, Department of Medicine. Such patients must meet all other qualifications required of patients admitted to the Unit.
   b. Patients referred for admission by a Private Physician may be managed by the Private Physician with a consultation by the Psychiatrist-on-call or the patient may be admitted as a patient of the Psychiatrist or attending physician and the Private Physican as referring physician.
   c. Patients on the Medical Assistance Program may be referred by any of the above methods, however, they will be cleared for such admission by the Chief of the Department of Medicine and assigned to the Medical Attendant on Service.
   d. Patients who do not have financial resources will be admitted, only after referral, by an Alcoholics Anonymous sponsor who is to demonstrate the ability and the willingness to assume financial responsibility for this person.
3. The patient and/or responsible relative, upon admission, is required to sign an authorization for the Hospital to commit the patient to the appropriate State Mental Hospital if it should become necessary, as well as to be financially accountable for any expenses incurred in the

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transportation of the patient to the appropriate State Mental Hospital.

DISCHARGE POLICY

A. The length of stay for patients hospitalized in the Detoxification Unit is from three (3) to four (4) days. The maximum length of hospitalization in the Detoxification Unit will be ten (10) days.

B. An agreement has been obtained from the Superintendents of the State Mental Hospitals to accept any patient from the Detoxification Unit who is required to be hospitalized for more than a ten (10) day period.

Further inquiry may be made through Mr. John H. Weber, Coordinator and Alcoholism Counselor at the Hospital.

Physicians desiring information relating to other programs for alcoholics in Baltimore City may call Mr. Harry E. Shelley, Coordinator of Alcoholism Programs, Baltimore City Health Department.

Robert E. Farber, MD
Commissioner of Health



Louis Krause, MD, Chairman
Library and History Committee

Elizabeth Sanford
Librarian

Meeting of the Curators of Osler Library, Montreal, Canada

The privilege to attend the Meeting of the Curators of the Library at McGill University is accorded the chairman of the Library Committee of the Medical & Chirurgical Faculty. It probably was the first time the faculty was represented at such a meeting. The impressive factor about the meeting was the atmosphere of the love of books. It was a surprise to me to learn about the extent of the McGill University Library, more particularly the size of the Osler Library. Part of the library is dedicated to the preservation and the use of rare books, particularly the rarissimi. These books have to be cared for not only in the proper filing position, but also for their preservation; air conditioned cases and maintenance of a constant temperature. Because of the increased amount of attention these books deserve, and need, special curators are in charge of the various divisions of the library, such as a curator of the Osler Section. It was refreshing to listen to the discussions that took place exhibiting the familiarity with medical literature, more particularly relating to the history of medicine and the development of medical ideas. Many of the things that we accept as new today are the concepts of the ancients come to fruition. How true the saying is *"the farther back you can look, the farther in the future you see,"* or as Patrick Henry said, *"I see no way to judge the future but by the past."*

The agenda were varied with no ridigity maintained, so there was a free discussion in every direction.

There is a need for a place in our library for all Members of the medical profession to have easy access to any medical literature, and for displaying the very latest medical information. It would be a shortsighted policy to maintain books in our library of only practical utility. Our book shelves should contain any volume that is being used by medical scholars. It is true that the medical practitioner's first concern is with the living literature, thus we must meet their needs by subscribing to a great number of periodicals in our own and other languages. Our Library must offer the greatest hospitality to a variety of subjects. Some of our books contain written words of the framework of the time in which they were written, but today, have ceased to be oracles.

One can envision the future of our Library with its 86,000 volumes as one of the most important parts of our faculty. Incidentally this is just a little smaller than the Library at McGill University. It could serve 3 functions—1. Pertaining to current medicine. 2. The history of medicine going back 100 years more or less, and 3. Rare books division—those not ordinarily

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found in the average library, which would include a special section for the "rarissimi" books, the latter occupying a niche comparable to that accorded an ancient scroll of hallowed worth. This all would be under the control of a chief librarian, in addition there would be a curator for the various subdivisions. I am aware that this means a lot of time and work, nor am I unmindful of the expression of Ecclesiastes in which he states, *"of making many books, there is no end and much study is a weariness of the flesh."*

Louis Krause, MD
Chairman, Library Committee

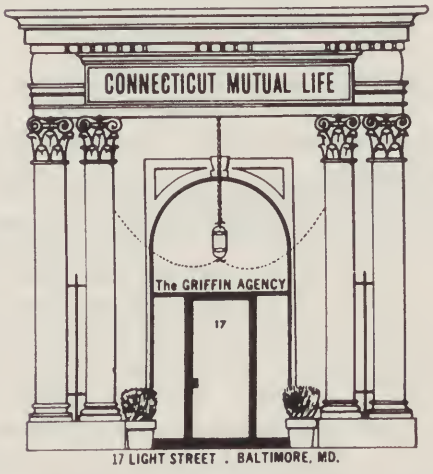
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Woman's Auxiliary

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JUNE, 1967

Woman's Auxiliary Elects First Honorary Member

The unanimous vote to elect Mrs. Albert E. Goldstein the FIRST HONORARY MEMBER of the Auxiliaries to the Baltimore City Medical Society and the Medical and Chirurgical Faculty of the State of Maryland was of noteworthy interest. Elsie Goldstein has more than earned this honorary membership for her fine leadership, her charm and devotion to Auxiliary work. A Charter member of the State and Baltimore City Auxiliaries she has served as president of both, always helping wherever and whenever needed on committees.

Her leadership ability was recognized by the Woman's Auxiliary to the American Medical Association, where she held the office of Director for two years and served as Chairman of the Resolutions Committee and member of the Nominating Committee. For the past year she has been Liaison Officer to the Woman's Auxiliary of the Student American Medical Association and has opened her home and heart to these outstanding young women.

Elsie's thirst for knowledge drew her to Johns Hopkins University for various courses, including some on Shakespeare. She is a member of the Daughters of the American Revolution. Sharing her late husband's interest in parliamentary procedure, she became a charter member of the *Margaret W. Wheelock* unit of the National Association of Parliamentarians. She is also an enthusiastic gardener. Always interested in her husband's career, she accompanied him to numerous medical meetings in many lands. She is the mother of four sons (two business men, an attorney and a physician) and has five grandchildren. Her fiftieth wedding anniversary was celebrated in 1962, five years before the demise of Dr. Albert Goldstein in February, 1967.



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Mrs. John E. Baybutt of Easton, Eastern Regional AMA ERF Chairman

Mrs. DeWitt DeLawter of Bethesda, Chairman of Legislation

Mrs. Richard Bauer of Adelphi, wife of the President of the Medical and Chirurgical Faculty of the State of Maryland

Alternates:

Mrs. James Garey of Aberdeen, President of the Woman's Auxiliary to Harford County

Mrs. Elmer Linhardt of Annapolis, Chairman of Members-at-Large

Mrs. Leonard Warres, President-elect of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland

Mrs. William S. Stone will attend as a member of the Board of Directors of the Woman's Auxiliary to AMA

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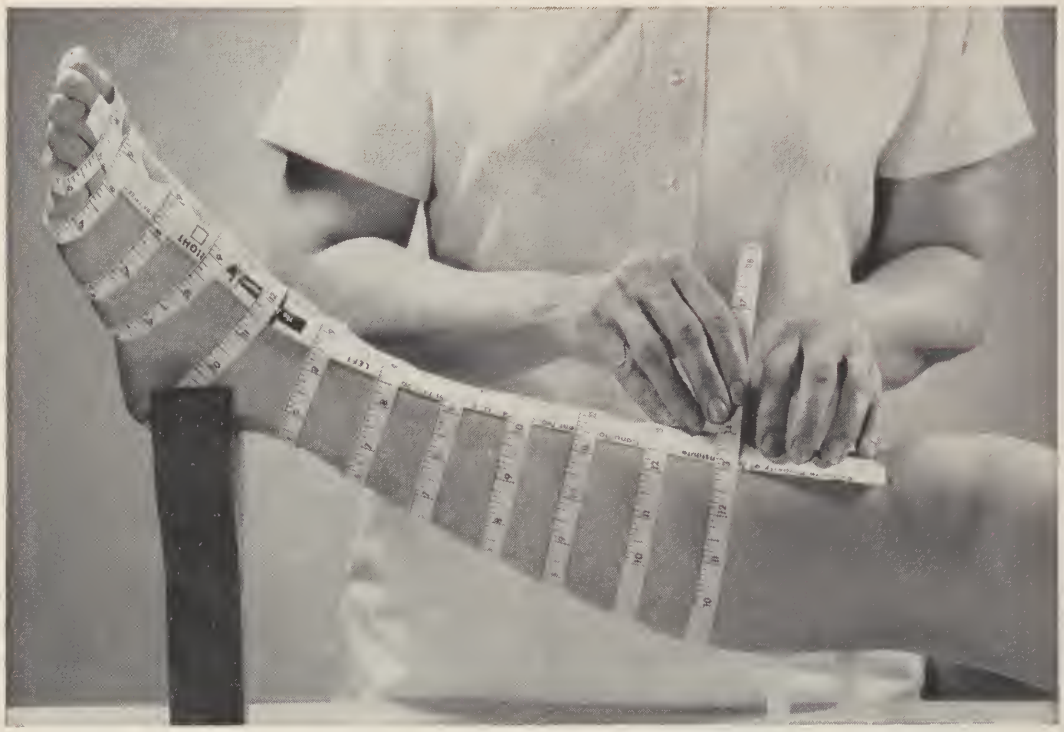
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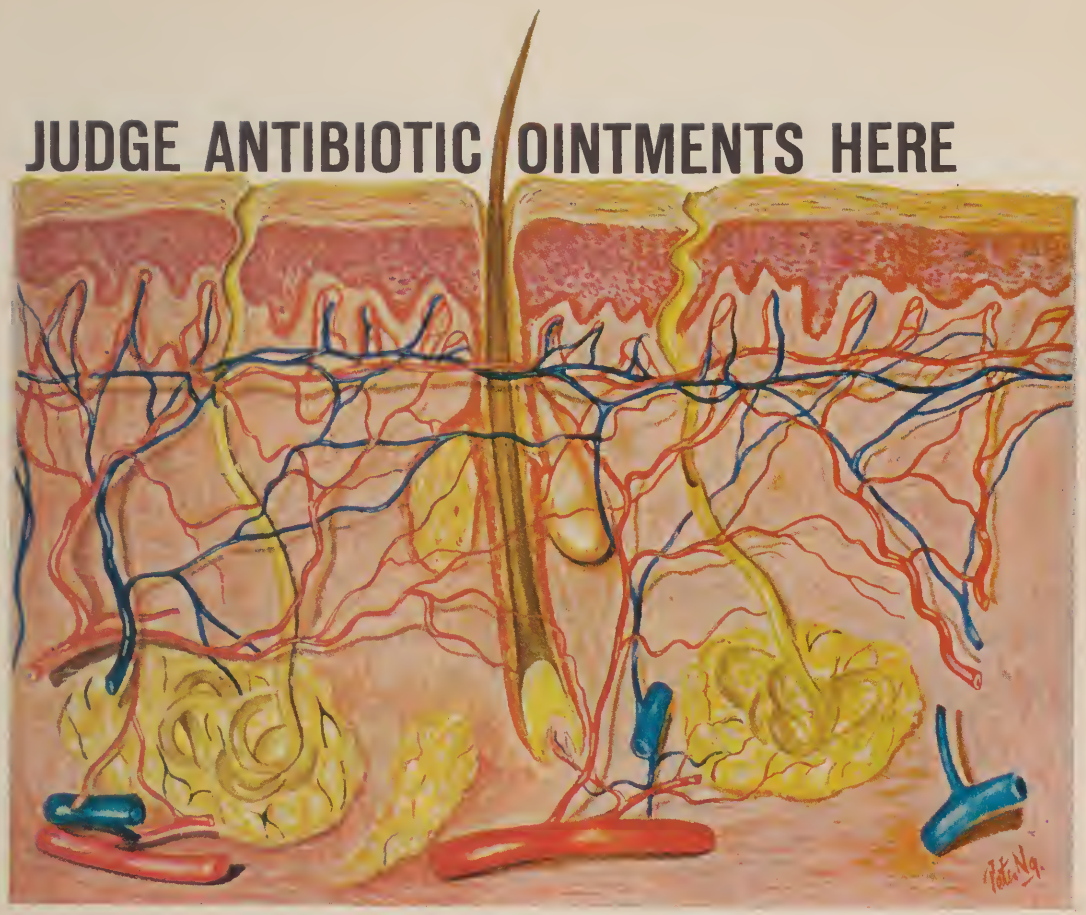
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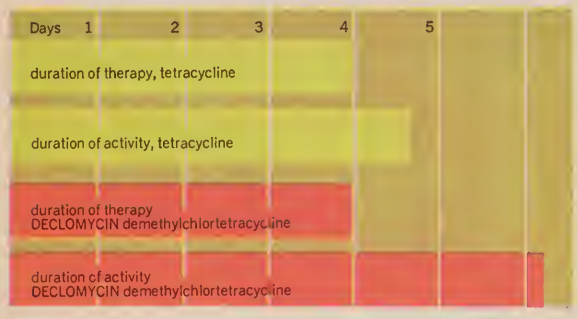
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Precautions and Side Effects—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measu should be taken. Use of demethylchlortetracycline dur tooth development (last trimester of pregnancy, neona period and early childhood) may cause discoloration the teeth (yellow-grey-brownish). This effect occurs mos during long-term use but has also been observed in sh treatment courses. In infants, increased intracranial pr sure with bulging fontanels has been observed. All sig and symptoms have disappeared rapidly upon cessat of treatment. Side reactions include glossitis, stomati proctitis, nausea, diarrhea, vaginitis and dermatitis adverse reaction or idiosyncrasy occurs, discontinue m ication and institute appropriate therapy. Anaphylact reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b. Should be given 1 hour before or 2 hours after mea since absorption is impaired by the concomitant adm istration of high calcium content drugs, foods and so dairy products.

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Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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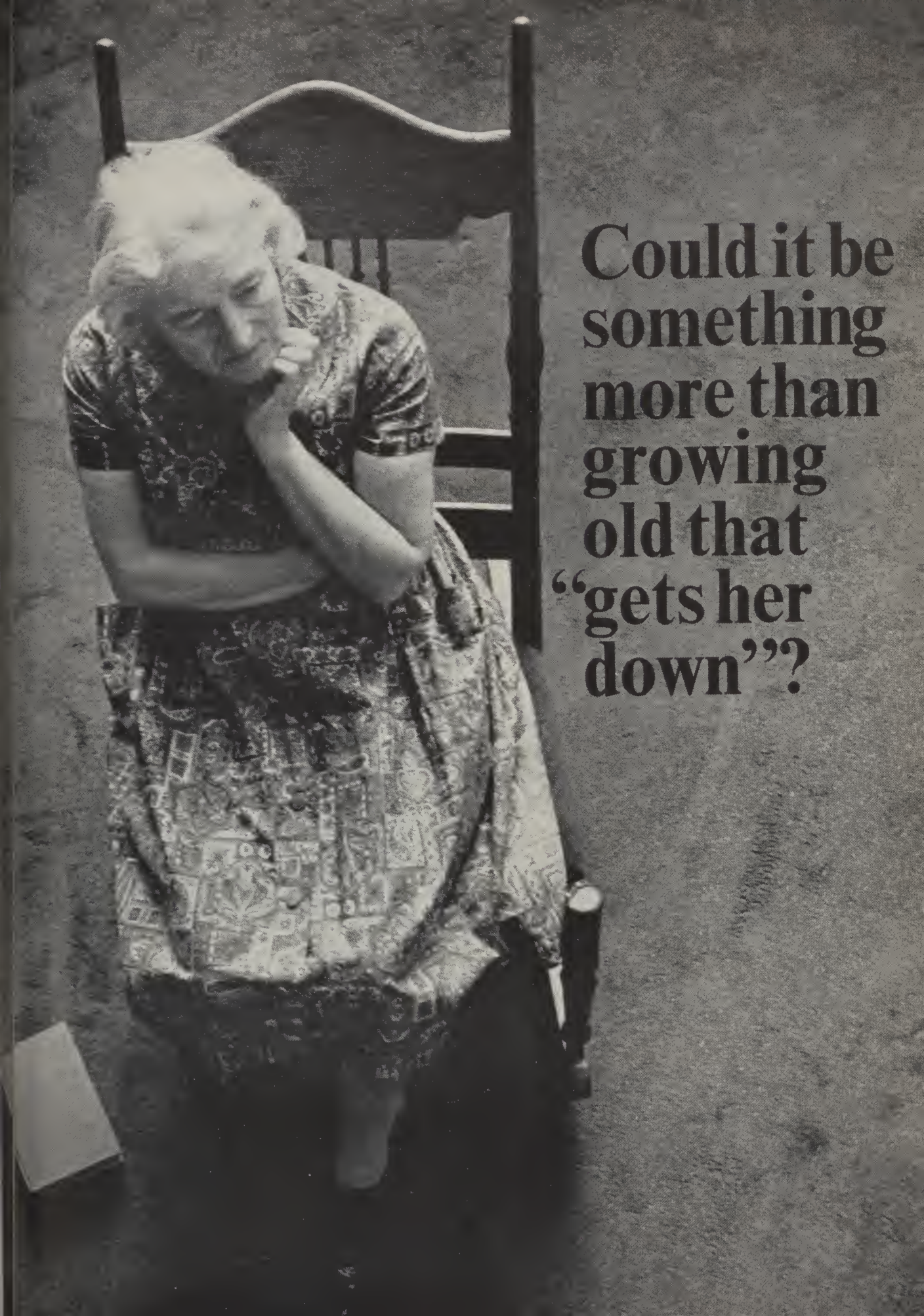
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IN BRIEF: One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth, blurring of vision, constipation, nausea, vomiting, bloating and dizziness may occur but are usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy — withhold in glaucoma. Contraindicated in patients sensitive to phenobarbital and/or Cantil (mepenzolate bromide); in toxic megacolon, obstruction of G.I. or G.U. tract.

SUPPLIED: CANTIL (mepenzolate bromide) — 25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL — containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

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Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%, pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin B_1) (10 MDR*), 10 mg.; riboflavin (vitamin B_2) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin B_6), 1 mg.; niacinamide (5 MDR), 50 mg.; choline,† 100 mg.; inositol,† 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.

Indications: 1. Functional fatigue such as that often associated with: a depressing experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

Contraindications: As with other drugs with CNS stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive compulsive states.

Side effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

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Precautions: Tuinal should be used cautiously in patients with decreased liver function, since prolongation of effect may occur.

Adverse Reactions: Idiosyncrasy, such as excitement, hangover, or pain, may appear. Hypersensitivity reactions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.



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ALL ABOUT AIDES - PART II

INTERVIEWING PROSPECTIVE AIDES

WILBURN L. McCLURE, JR.

Prior to sitting down with an applicant, the doctor should have the following:

1. An application form.
2. A written description of the position to be filled.
3. A private area and an unhurried hour.
4. A few well-chosen words describing the doctor's personality and idiosyncrasies.

When possible, mail an application form prior to the interview. Ask that it be completed and returned; and state that if your review of the form is favorable, an interview will be arranged.

In this way, you can observe the applicant's handwriting ability or typing skills. Also, you can review her qualifications, work experience, salary requirements and references. If the references prove favorable, you are ready to conduct a professional interview.

Should the applicant come directly to your office, provide a private place in which the form can be completed. Take time to review the application prior to admitting the applicant to your consultation room. If possible, make one quick phone call to check a reference; otherwise, make sure that you complete this task after the interview.

Interviews that are conducted in the privacy of a consultation room should be unhurried. Try not to take phone calls. After all, these few minutes must provide you and the applicant with information that you need regarding each other, or it might as well not have been conducted.

Without an outline of the position to be filled, the doctor cannot relate to the applicant the full scope of the intended responsibility. The written description of the position should be two-fold—something like the following:

ROUTINE DUTIES: Open the office by 8:45 A.M.; make sure the entire office is in a tidy condition; review pre-pulled medical history files; call the answering service for messages; answer the phone; greet patients; prepare charge slips; accept payments; make appointments; advise patients about preparations for special tests; prepare patients for examination; assist the doctor during examinations, when required; open and sort mail; post daily log; prepare daily deposits; schedule surgery; type letters, reports and insurance forms; prepare patients' monthly financial billing; keep filing current; order the doctor's lunch, etc., etc., etc.

SPECIAL DUTIES: Take deposits to the bank; inventory and order drugs and supplies;

Mr. McClure is director of the Baltimore office of Professional Business Management, Inc. This monthly column is prepared as a complimentary service to the *Maryland State Medical Journal.*

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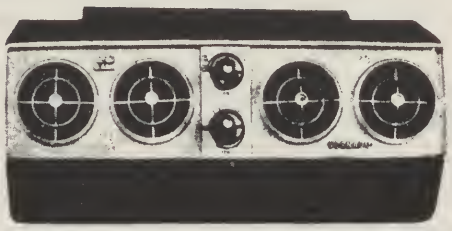
supervise cleaning personnel; sterilize equipment; check the doctor's bag; remind the doctor of special meetings and events; maintain professional and administrative equipment, etc., etc., etc.

Far too often the doctor is unable to describe adequately the position to be filled. This leads to mass confusion later when the aide finally learns that she has much more to do than answer the phone and greet the patients. This shock leads to a resignation or to an apathetic condition where she does as much as she can get done.

If you decide to hire the applicant immediately, the salary, the hours, vacations, sick leave and overtime must be fully discussed and understood. Also, let her know whether she is to wear a uniform, and if so, who bears the purchase and maintenance cost.

The thoroughly planned interview can be a very rewarding experience even if you decide not to hire the applicant. If you gave the applicant a fair chance and she did not pass, at least you will be able to say that you rendered a judgment based upon fact and not upon pure conversation.

Next month Part III will discuss "Ways to Keep a Valued Aide."



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Book Reviews

THE PAPERS OF ALFRED BLALOCK, Vols. I and II. Johns Hopkins Press.

These collected papers edited by Mark Ravitch, MD, trace the life of Dr. Blalock from his early, formative years at Vanderbilt, until his death shortly after his retirement in 1965. It consists of a compendium of all his various articles published in this country, as well as others. Adequately indexed and referenced it is an outstanding work. Because of Dr. Blalock's interest in the Faculty and it activities, as well as Dr. Ravitch's connection with Baltimore and The Johns Hopkins Medical Institutions, this would be an excellent work that would add much to the library of any person who receives it.

THE OCULAR FUNDUS IN NEUROLOGIC DISEASE; William Fletcher Hoyt, MD and Diane Beeston, AB; The C V Mosby Company, St. Louis.

This manual and atlas is designed for medical specialists responsible for the evaluation, counsel and treatment of patients with diseases of the Central Nervous System. The illustrations of the ocular fundus were taken from the extensive stereophotographic records collected during recent years at the University of California School of Medicine. It is a well illustrated book and one that has been needed in this field.

AN ATLAS OF FIGURE DRAWINGS, Caroline Bedell Thomas, MD; The Johns Hopkins Press, Baltimore.

This is the third volume in a series devoted to various indices dealing with psychological testing and is devoted to an analysis of drawings made by medical students of the Johns Hopkins Medical School. It evaluates the drawings using a scale so that the individuals can be rated according to their parental histories in relation to coronary disease, hypertension, stroke, diabetes anl obesity.

STEREOSCOPIC ATLAS OF MASTOIDOTYMPANOPLASTIC SURGERY; Harold F. Schuknecht, MD; Werner D. Chasin, MD; and John M. Kurkjian, MD; The C V Mosby Company, St. Louis.

The purpose of this atlas is to show the important histopathologic changes in chronic suppurative middle ear and mastoid disease, to describe the technique of mastoidotympanoplasty, and to present our method for teaching temporal bone surgery to house officers. It accomplishes this purpose remarkably well.

SYNOPSIS OF NEUROLOGY, Francis M. Forster, BS, MD; The C V Mosby Company, St. Louis.

This is the second edition of this publication and has been prepared with the same concept as the first, that of maintaining simplicity and essentiality in the presentation of clinical neurology. It is a book primarily for medical students, but it can be widely used by those in the paramedical field. It is a valuable book for use in libraries and for reference purposes.

CURRENT CONCEPTS IN OPHTHALMOLOGY, Bernrd Becker, MD, and Robert C. Drews, MD; The C V Mosby Company, St. Louis.

This book represents a compilation of selected topics representing current clinical work and interests of the staff of the Department of Ophthalmology, Washington University School of Medicine, St. Louis, Missouri. It is meant to be read at leisure and provides the reader with useful and provocative material.

US ARMY IN WORLD WAR II, Charles M. Wiltse, US Government Printing Office.

This publication is one of many in a series and is devoted to The Technical Services, and in particular, The Medical Department: Medical Service in the Mediterranean and Minor Theaters.

As always, these publications constituting a rerord of the US Army in World War II, are well written, albeit somewhat dull to read. In any event, it provides for the historian, a valuabe reference to what happened and just how well and much improved the medical services in World War II were.

ALLEGANY COUNTY

Officers of the Allegany County Medical Society for the current year are:

President: **L. Michael Glick, MD**
Vice-President: **Lester Kiefer, MD**
Secretary: **Robert F. Miller, MD**
Treasurer: **Albert P. Marsh, MD**

On Sunday, May 7, 1967, the Allegany County Medical Society, in conjunction with the Medical and Chirurgical Faculty of the State of Maryland, State Health Department and County Health Department, carried out a mass vaccination program against measles for children age 1-9. **Robert Brodell, MD** and **Elmer L. Hill, MD** were co-chairmen of the program and in spite of inclement weather, 2,104 children were successfully inoculated, using the hypospray type injection. The attendance exceeded expectations and included children from neighboring counties of Mineral (West Virginia) and Garrett (Maryland).

On Wednesday, May 10, 1967, our Society toured the Allegany Ballistics Laboratory of the Hercules Powder Company in nearby Rocket City, West Virginia. Following a social hour and dinner in the plant cafeteria, the doctors, escorted by scientists in charge of various departments, were shown all the operations that are not classified, including the actual production of various stages of the Sprint Anti-missile Missile which is assembled and tested at the local subsidiary.

The new Sacred Heart Hospital on Haystack Mountain started receiving patients on March 28th. The modern, 250 bed, $8,000,000 facility fills a void which had become quite acute in the Cumberland area. The new hospital has also opened three new departments, mainly: psychiatry, intensive care and maternity. The dedication of the new institution will be June 11, 1967.

Plans for one and possibly two nursing homes in the area are in the process of being put into the building phase. These institutions are expected to ease the burden of the hospitals in the care of the chronically ill.

On May 10, 1967, in observance of National Hospital Week, Society members, and all heads of departments in both hospitals met at a luncheon with the administrative, nursing and lay people of both hospitals. The meeting was held at the local Ali Ghan Shrine Country Club with Rudolph J. Pendall, executive director of the Hospital Council of Maryland, Inc., as the principal speaker.

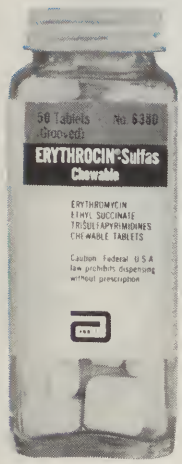
Recent additions to the Society membership have been: **Andrew Stasko, MD,** general surgery; **C. Herschel King, MD,** anesthesiology; **Frank Fagan, MD,** psychiatry; **Ingeborg C. Dross, MD,** internal medicine; **Drs. William Newman, Robert F. Miller** and **John P. Light,** radiology; and **Elmer L. Hill, MD,** County Health Officer. **Drs. John A. Topper, Vasilios P. Dross** and **William Francis** provide round the clock coverage in Memorial Hospital Dispensary while **Drs. Nelson C. Estruch** and **Leo H. Ley, Jr.** provide dispensary coverage at Sacred Heart. These physicians in both institutions

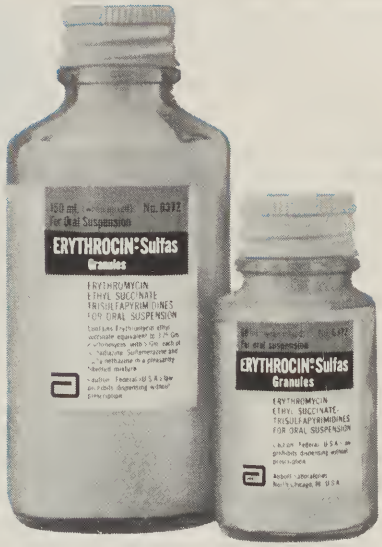
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1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

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Brief Summary on next page

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Brief Summary

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Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

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Calvin Y. Hadidian, MD, plans to return to practice in Cumberland in the near future. He has been on a one year leave of absence for further study and research in thoracic and cardiac surgery, six months of which was spent training in the veteran's facility in Chicago.

Mrs. Nancy Spiggle, R.N. assumed the position of Director of Nursing Service at Memorial Hospital on May 1st. Mrs. Spiggle is the wife of **Wayne C. Spiggle, Jr., MD,** a local internist.

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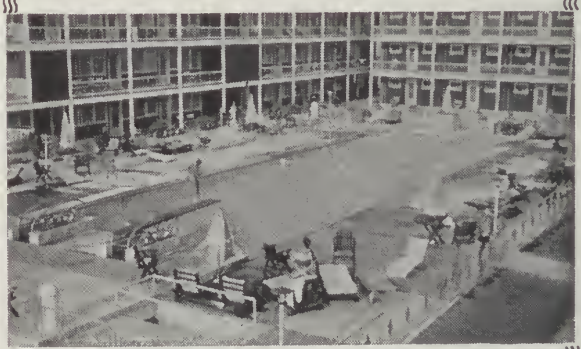
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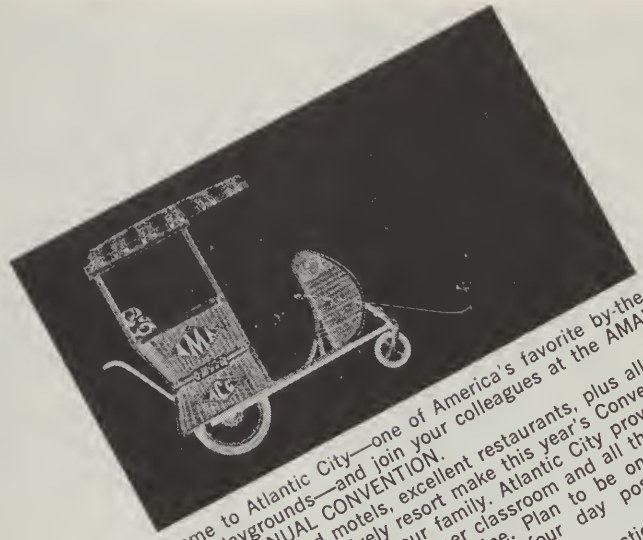


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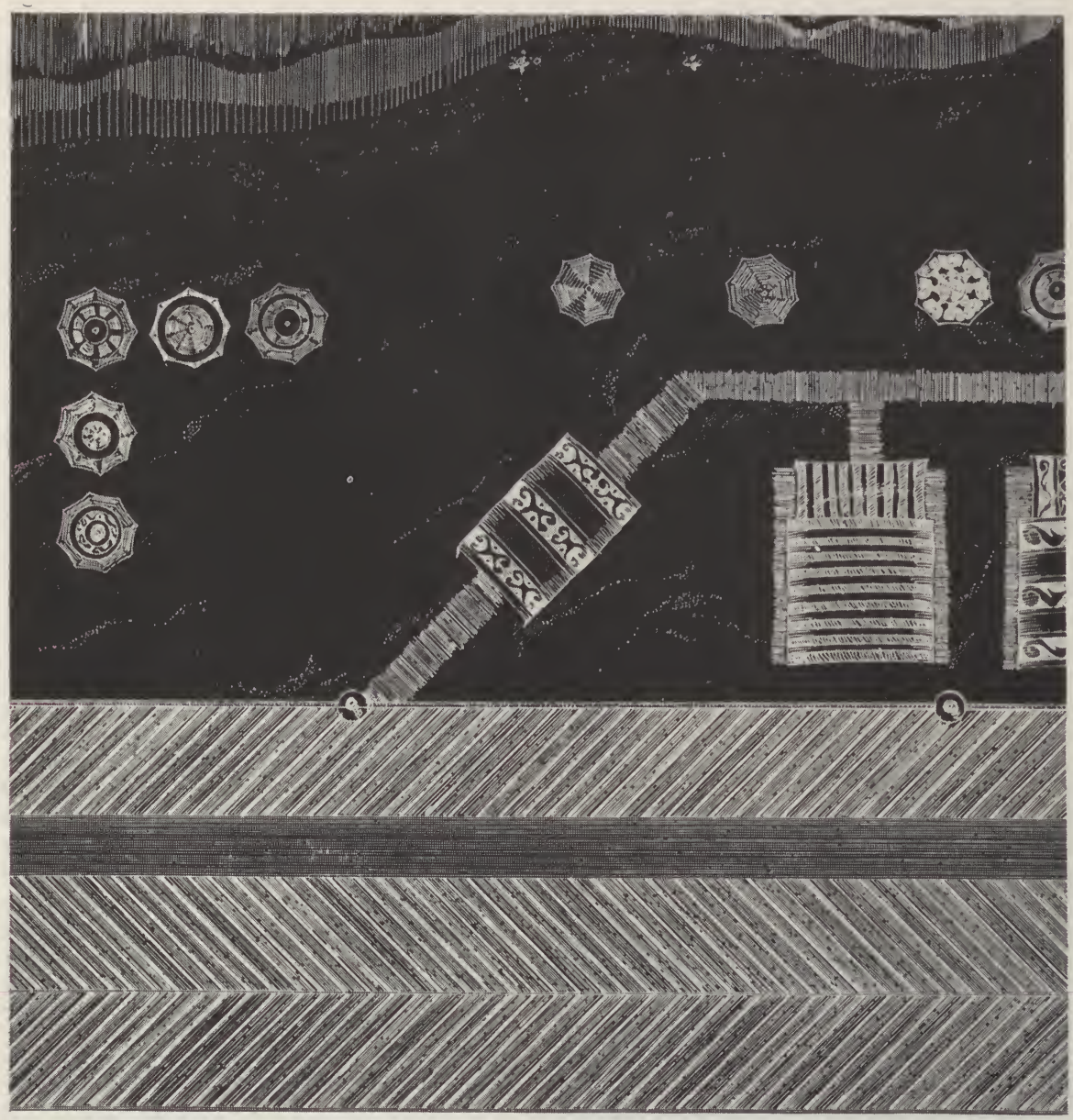
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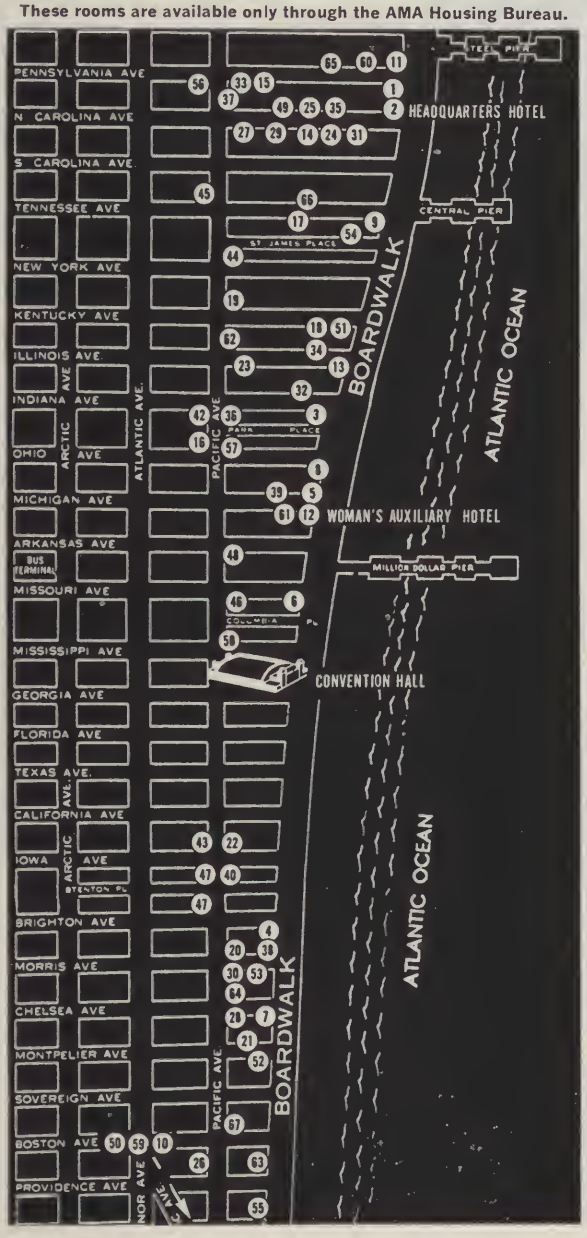
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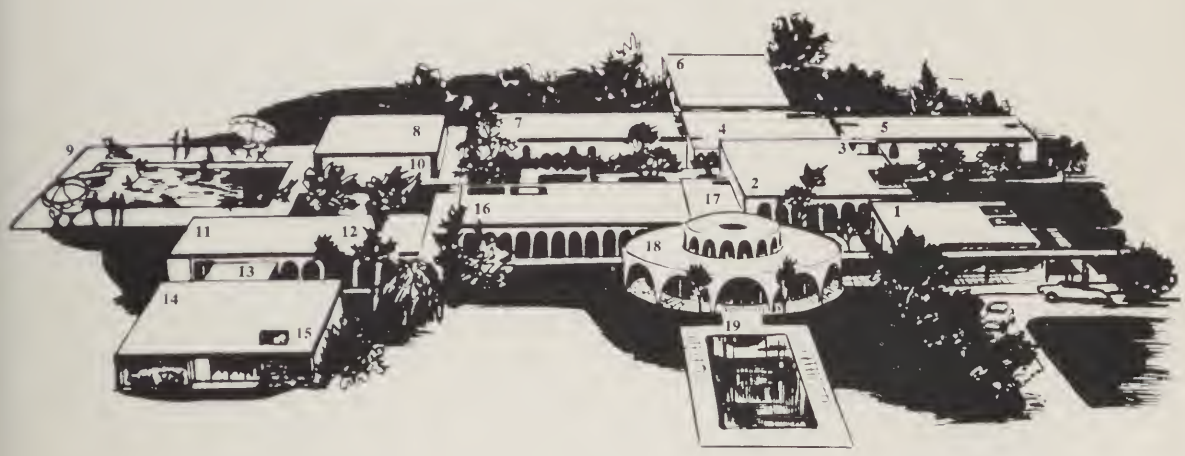
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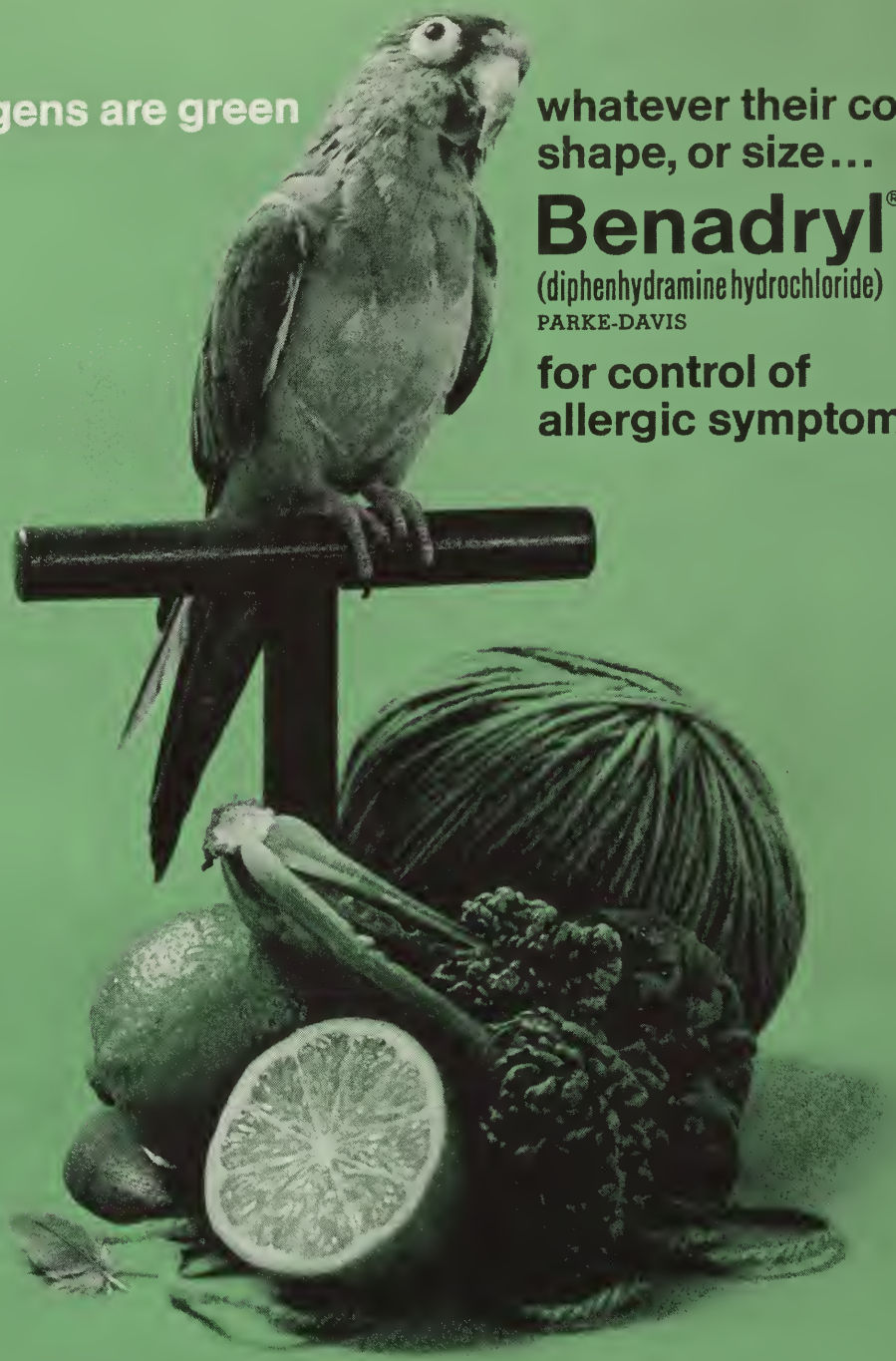
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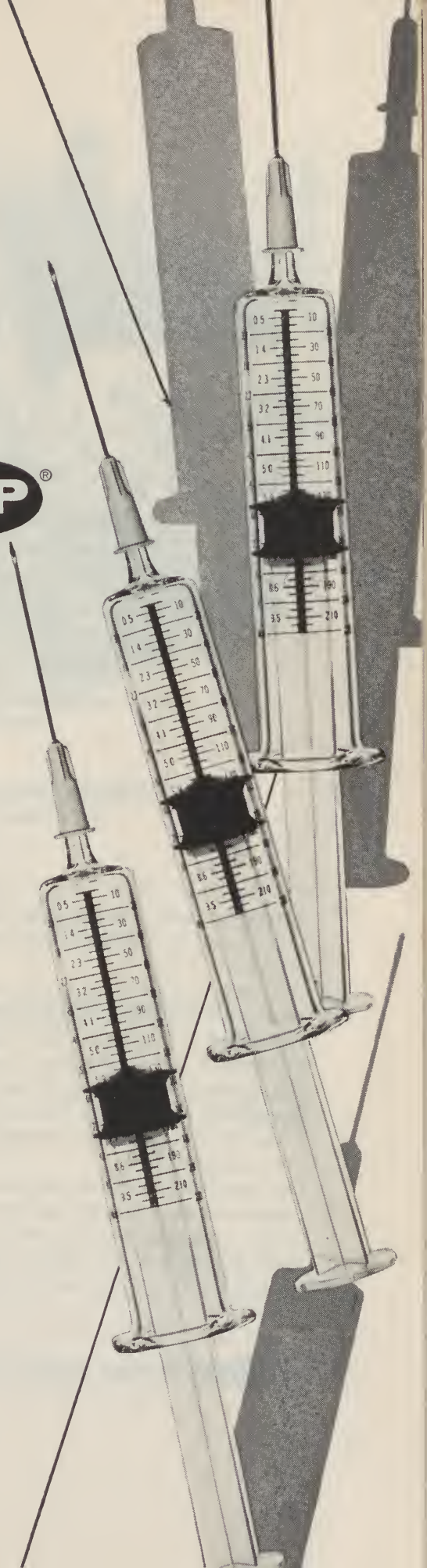
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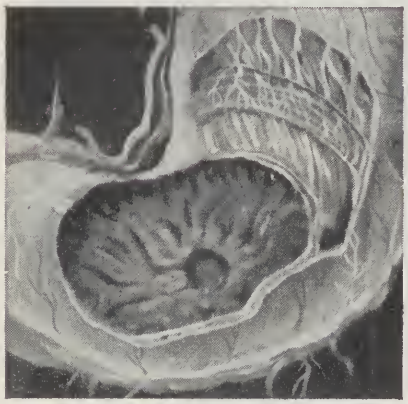
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Doctors take note...

August 14-18
Golden Anniversary Meeting—Conrad Hilton Hotel. Contact: The American Dietetic Association, 620 North Michigon Ave., Chicago, Ill. 60611.

THE AMERICAN DIETETIC ASSOCIATION

August 14-16
The Committee on Sports Medicine of the American Academy of Orthopaedic Surgeons will hold a Post-Graduate Course on Sports Medicine at Skirvin Hotel, Broadway and Park Avenue, Oklahoma City, Oklahoma 73125. Contact: Don H. O'Donoghue, MD, 1111 North Lee St., Oklahoma City, Oklahoma 73103.

AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS SPORTS MEDICINE PROGRAM

August 14
Seminar on the Medical Aspects of Sports at Catonsville Community College, Catonsville, Md. Contact: The Medical and Chirurgical Faculy, 1211 Cathedral St., Baltimore 21201, Md. LE 9-0872.

SEMINAR ON MEDICAL ASPECTS OF SPORTS SPONSORED BY THE MEDICAL & CHIRURGICAL FACULTY OF THE STATE OF MARYLAND AND CATONSVILLE COMMUNITY COLLEGE

September 8-9
Semiannual Meeting—Medical and Chirurgical Faculty of the State of Maryland at Ocean City. Contact: Medical and Chirurgical Faculty, 1211 Cathedral St., Baltimore, Md. 21201. LE 9-0872.

MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND SEMIANNUAL MEETING

September 21-24
27th Annual Meeting of the American Medical Writers Asociation—Palmer House, Chicago. Contact: AMWA, P.O. Box 267, Arlington, Va. 22210.

AMERICAN MEDICAL WRITERS ASSOCIATION

October 4, 1967—March 27,1968
Wednesday 1-4 p.m.
General Internal Medicine. Postgraduate Course. Contact: 230 North Broad St., Philadelphia, Pa. 19102.

HAHNEMANN MEDICAL COLLEGE AND HOSPITAL

October 21-26
36th Annual Meeting af American Academy of Pediatrics—Washington Hilton Hotel, Washington, D. C. Contact: American Academy of Pediatrics, 1801 Hinman Ave., Evanston, Ill. 60204.

THE AMERICAN ACADEMY OF PEDIATRICS

November 26
9th National Conference on the Medical Aspects of Sports, in conjunction with the Annual Clinical Convention of AMA at Houston, Texas. Contact: Fred V. Hein, Ph.D., 535 North Dearborn St., Chicago, Ill. 60610.

MEDICAL ASPECTS OF SPORTS AMERICAN MEDICAL ASSOCIATION ANNUAL CLINICAL CONVENTION

November 26-29
Annual Clinical Convention of the AMA—Houston, Texas. Contact: 535 North Dearborn St., Chicago, Ill. 60610.

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From Washington

The Department of Health, Education and Welfare is making a broad study of prescription drugs which will be the basis of a recommendation on whether their costs should be covered by medicare when they are used outside a hospital.

HEW Secretary John W. Gardner appointed a task force of *HEW* officials to evaluate the study and make the recommendation.

"Prescription drugs are an essential element of modern medical care," Gardner said. "In the last twenty-five years we have witnessed greater advances in the use of drugs than in the whole previous history of medicine. Today drugs and biologicals make possible the prevention and successful treatment of illnesses that were serious and frequently fatal.

"Yet for many older Americans the cost of needed drugs prescribed by a physician is a heavy burden, representing 15 to 20 per cent of their medical care costs. Many older Americans find themselves with limited financial resources at the very time that age brings an increasing incidence of chronic disease and greater needs for medical care, including prescription drugs."

President Johnson directed last January that Gardner "undertake immediately a comprehensive study of the problems of including the cost of prescription drugs under medicare." Studies on some aspects of the question were started then and are near completion. Other specific studies are in various stages of progress.

But Congress may decide the issue before the full study is completed. The Senate Finance Committee will hold hearings this summer on such a medicare extension.

Philip R. Lee, MD, Assistant *HEW* Secretary and Chairman of the task force, said that even if the study is incomplete, *HEW* will take a stand anyway when the Senate Finance Committee takes up the legislation.

One bill would finance medicare coverage of drugs by increasing from $3 to $4 the cost of monthly premiums for the voluntary doctor bills insurance program (Plan B) for persons 65 and over. Sponsored by Sen. Joseph M. Montoya (D., N.M.) the bill would provide that generic drugs rather than trade name products be used whenever possible.

Another bill is sponsored by Chairman Russell B. Long, (D., La.), the Senate's leading critic of the drug industry. It would spur generic purchasing for all federally-connected welfare programs.

"The task force will examine a number of factors which are closely involved with the use of prescription drugs and with present and proposed methods of purchasing them," Lee said. "Many of these factors concern not only drug costs—and who pays them—but also the quality of medicare care."

Among the major areas listed for task force study:

1. Present patterns of drug prescription by physicians.
2. Present patterns of prescription drug use and expense by patients.
3. Present resources used to meet drug costs (including personal resources, aid from relatives, insurance, government assistance).
4. Present drug cost coverage programs (including federal, state, commercial insurance, union, and foreign programs).
5. Distribution systems (including independent pharmacies, central pharmacies, mail-order distribution, physician dispensing, and hospital dispensing).
6. Reimbursement factors (including determination of costs; co-insurance; deductibles; and limitations on dollar costs, drug quantities, and drug types).
7. Accounting methods (including nomenclature, coding, data processing).
8. Pharmacological aspects (including generic equivalents vs. clinical equivalents).

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9. Clinical aspects (including formulatory systems).
10. Legal and fiscal aspects.
11. Impact of proposed methods of purchasing prescription drugs on costs and quality of patient care, on medical profession, on pharmacy profession, on drug industry, on government.

* * * * *

Surgeon General William H. Stewart says that measles (Rubella) should be eradicated this year but other cripplers and killers like venereal disease and cancer still baffle researchers.

"This year, 1967, may well go down in history as the year of measles eradication in the United States," Stewart told a House Appropriations Subcommittee, in testimony recently published.

Stewart said the measles vaccine, licensed four years ago, is "bringing the disease to the vanishing point." The Public Health Service researchers now are working with an "experimental vaccine" trying to conquer German measles, he said.

Other health problems, such as cancer, heart disease and gonorrhea, continue, however, to pose numerous research problems, Stewart reported.

Stewart told the Appropriations Subcommittee that the "fastest rising causes of death and disability" in this nation are emphysema and other chronic respiratory diseases. He said deaths from emphysema and chronic bronchitis have increased about nine times in the last 20 years, causing more than 60,000 deaths a year.

* * * * *

The federal health official, who estimated that some 300,000 people die each year indirectly from smoking, also reported that a new less dangerous cigarette may be developed.

"There is reason to believe that the development of a less hazardous cigarette is potentially within reach," he said. But he put no timetable on development of this type of cigarette.

* * * * *

The *AMA* supports all except one provision of legislation (S. 780) that would expand the federal government's role in the federal-state program to curb air pollution.

In a letter to the Senate Subcommittee on Air and Water Pollution, F. J. L. Blasingame, MD, executive vice president of the *AMA*, pointed out

that the *AMA* has been directing the attention of physicians and other health workers to the problems of air pollution through a series of meetings and its publications. He also noted that the *AMA* has supported such legislation in past years.

"In spite of past legislation and on-going federal, state and local programs which are carried on in cooperation with private industry, the *AMA* recognizes that air pollution continues as a major environmental problem," Dr. Blasingame said. "Increased program emphasis on research and development in techniques of air pollution control and abatement is worthy of the support of the medical profession.

"The bill before you contains one provision which we cannot support. Section 107 of S. 780 would require the Secretary of *HEW* to establish emission standards for certain industries. On the basis of present information and understanding of the relationship between emissions and the effect it has on surrounding air, such a requirement is unrealistic and would not accomplish its intended purpose."

* * * * *

Applications Now Being Accepted for Fellowships in Medical Education

The American Heart Association is now accepting applications for Fellowships in Medical Education for the 1968-69 academic year.

The program is designed to stimulate careers in the field of research in medical education. Fellows receive training in a medical school's department of Research in Medical Education, where they are taught to analyze learning processes and modern teaching methods in preclinical and clinical fields. In addition, they study behavioral psychology and participate in pilot projects in continuing education.

US citizens or those intending to become citizens, who hold either an MD, PhD, ScD or its equivalent, are eligible to apply. To meet the needs of candidates with varied backgrounds and experience, the stipend is based on qualifications and will be at least on the senior postdoctoral level.

Application forms may be obtained from the Director of Medical Education, American Heart Association, 44 East 23rd St., New York, N.Y. 10010. Sept. 15, 1967 is the deadline for receipt of applications

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From Baltimore

The University Hospital, University of Maryland, Baltimore, Maryland, has become the first hospital to be awarded the United States Air Force Air Reserve Forces Outstanding Support Award. In recent Washington, D. C., ceremonies, the hospital became the first medical facility to be singled out by Air Force Secretary Harold Brown.

The citation is awarded on behalf of the Secretary of the Air Force to businesses and industries who lend outstanding, active support to Air Reservists and the Air Reserve Forces. Companies so honored have normally established policies or programs which not only permit Reservists to engage in AF Reserve activities, but actually encourage qualified employees to continue to assist in the national security by becoming productive members of the AF Reserve and Air National Guard.

In addition to cooperative policies regarding individual AF Reservists and their military activities, the University Hospital was specifically recognized for its open-handed donation of its medical facilities to enable reservists to update and maintain professional skills.

For the past several years, the hospital has permitted Medical Reservists, both as individuals and as units, to maintain their proficiency by working side by side with staff members in the hospital's wards, clinics, and laboratories. The skills of the reservists have been maintained to such a fine degree that they now devote the considerable portion of their activities to the



George Yaeger, MD (right) Director University Hospital, University of Maryland, Baltimore, is presented the Air Reserve Forces Outstanding Support Award by Theodore C. Marrs, MD, Deputy for Reserve and ROTC Affairs, Office of Special Assistant for Manpower and Reserves, Office of the Secretary of the Air Force. The University Hospital was selected for the citation, presented on behalf of the Secretary of the Air Force because of its outstanding support of Air Force Medical Reservists in the Baltimore area. Doctor Marrs presented the award during the Medical Reserve Symposium held in conjunction with the Aerospace Medical Association Convention in Washington, D. C., April 10-13.

actual care of Aeromedical evacuation patients from Vietnam.

The hospital had opened its facilities to Baltimore reservists of the Continental Air Command's 22nd Medical Service Squadron and 403rd Medical Service Flight by allowing them the use of hospital facilities for training.

Doctor Theodore C. Marrs, Deputy for Reserve and ROTC Affairs, Office of Special Assistant for Manpower and Reserves, Secretary of the Air Force, represented Secretary Brown in presenting the Air Force Citation to Doctor George Yaeger, University Hospital Chief of Staff, on April 13.

The presentation was made during the 4th Annual Medical Reserve Symposium held in conjunction with the 38th Annual Scientific Meeting of the Aerospace Medical Association in Washington, D. C.

* * * * *

The 18th Annual Business Meeting and the Election of Officers of the Maryland Academy of General Practice was held Sunday, May 21, 1967, at the Washingtonian Motel, Gaithersburg, Maryland.



The retiring President of the Maryland Academy of General Practice, G. Overton Himmelwright, MD (left) receives a plaque from the New President of the Academy, John G. Ball, MD of Bethesda.

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Officers, Directors and Delegates—1967—Elected

President: John G. Ball, MD, Bethesda.

President Elect: Leon Berube, MD, Mechanicsville.

Vice Presidents (1 year): Western Maryland; William L. Stewart, MD, Westminster; Southern Maryland; James P. Jarboe, MD, Great Mills; Baltimore City and County; John C. Hyle, MD, Baltimore; Eastern Shore; C. Rodney Layton, MD, Centreville.

Secretary (2 years): G. Overton Himmelwright, MD, Cumberland.

Treasurer (2 years): Harry Knipp, MD, Baltimore.

Directors (2 years): Western Maryland; Frank B. Thomas, MD, Hancock; Southern Maryland; Fred Johnson, MD, LaPlata; Baltimore City and County; John Chissell, MD, Baltimore; Eastern Shore; Richard Tyson, MD, Easton.

Delegate (2 years): Roy Guyther, MD, Mechanicsville.

Alternate Delegate (2 years): Guy Reeser, MD, St. Michaels.

Other Officers Whose Term of Office Expires 1968

Directors: J. Dean Wilson, MD, Hagerstown; John B. Umhau, MD, Chevy Chase; Philip Heuman, MD, Bel Air; Irvin G. Hoyt, MD, Queenstown.

Delegate: Archie R. Cohen, MD, Clear Spring.

Alternate Delegate: Robert Farr, MD, Chestertown.

* * * * *



John H. Hirschfield, MD, president of Baltimore Area Council on Alcoholism, seen accepting from Mrs. Gretrude Nilsson, Coordinator of Service to Alcoholics, a Certificate of Appreciation for his outstanding contribution to the field of alcoholism. Mrs. Nilsson made the presentation on behalf of Isadore Tuerk, MD, Commissioner of the State Department of Mental Hygiene.

H E L P !

During the Annual Meeting at the Alcazar, the Library circulated books from the collection on exhibit there. One book, however, strayed away without being charged, so should anyone find the following title (with the Med-Chi ownership stamp, of course) among his own library, we would appreciate his sending it back to us:

Shindell, Sidney, Statistics, Science and Sense (RA 407 S4 1964)

Doctor, Do Your Patients Understand Your Fees?

Patients hesitate to ask about fees. But they want to know. They naturally worry about what their medical costs will be. And if they don't feel free to talk about it, serious problems—misunderstanding, resentment and even deep hostility can arise, threatening the all-important rapport between you and your patients.

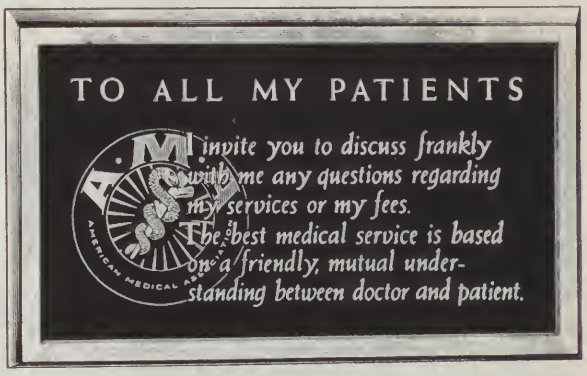
Open discussion *before* treatment prevents such embarrassing problems. It paves the way for mutual understanding and good will.

An *AMA* Fee Plaque, prominently displayed in your waiting room, serves as an open invitation for your patients to discuss medical costs and financial problems with you. It shows that you care. Just seeing the message can give many financially worried patients peace of mind.

The *AMA* Fee Plaque works hard to prevent doctor-patient misunderstandings. And it works well.

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MEDICAL AND CHIRURGICAL FACULTY

Friday & Saturday, September 8 & 9, 1967

at

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(see page 23)

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EXECUTIVE SECRETARY'S NEWSLETTER

July, 1967

REFERENCE COMMITTEE MEETING

The Reference Committee will meet on

WEDNESDAY, AUGUST 23, at 8:00 p.m.

in the Faculty Building to discuss whatever resolutions have been received before the July 15 deadline for receipt of such resolutions.

At the time of this writing the only resolution received for consideration is:

1S/67 - Authorizing the seeking of enabling legislation to require compulsory membership in a component medical society of the Faculty in order to maintain high professional and ethical standards incident to the right and privilege of practicing medicine in Maryland.

SEMIANNUAL SESSION

The Semiannual Session will be held on Friday and Saturday, September 8 and 9, at the Diplomat Motel, Ocean City. Concurrent sessions of various specialty groups will be held at the same time. Full details will be in the mail to all members shortly.

ELECTIONS

The recently formed Maryland Urological Society has elected the following officers: John N. Robinson, M.D., Easton, President; Martin Robins, M.D., Baltimore, Vice President; Raymond Yow, M.D., Salisbury, Secretary-Treasurer.

The Maryland Association of Private Practicing Psychiatrists elected new officers at its annual session, as follows: Michael J. Bisco, President; R. Taylor King, Vice-President; Elihu E. Allison, Secretary-Treasurer; and Carl B. Schleifer, Program Chairman.

1968 CRUISE CONVENTION

Representatives will be on hand at the Semi-annual Session to take reservations for the 1968 Cruise Convention to the Caribbean. Dates of the cruise, held as part of the Faculty's 1968 Annual Meeting, are April 21 through April 28.

NEWS NOTES

Henry N. Wagner, Baltimore, has become the 27th President of the American Federation for Clinical Research. Dr. Wagner will serve through 1968.

James E. Carson, Baltimore, has been named Deputy Commissioner of the Department of Mental Hygiene.

New members of the American Dermatological Association include Raymond C. V. Robinson, Baltimore. This group is dedicated to the development of knowledge concerning skin diseases and its application to patient care.

Harold Rosen, Baltimore, recently conducted a seminar on The Frigid Patient and her Nymphomanic Sister at the Connecticut Valley State Hospital.

VOLUNTEER PHYSICIANS FOR VIET NAM

Louis Padovano, of Woodstock, has left for a 60-day stint as a volunteer physician to serve in Viet Nam. This period of voluntary service provides care to the civilian population and is sponsored by the American Medical Association in cooperation with the U S Government.

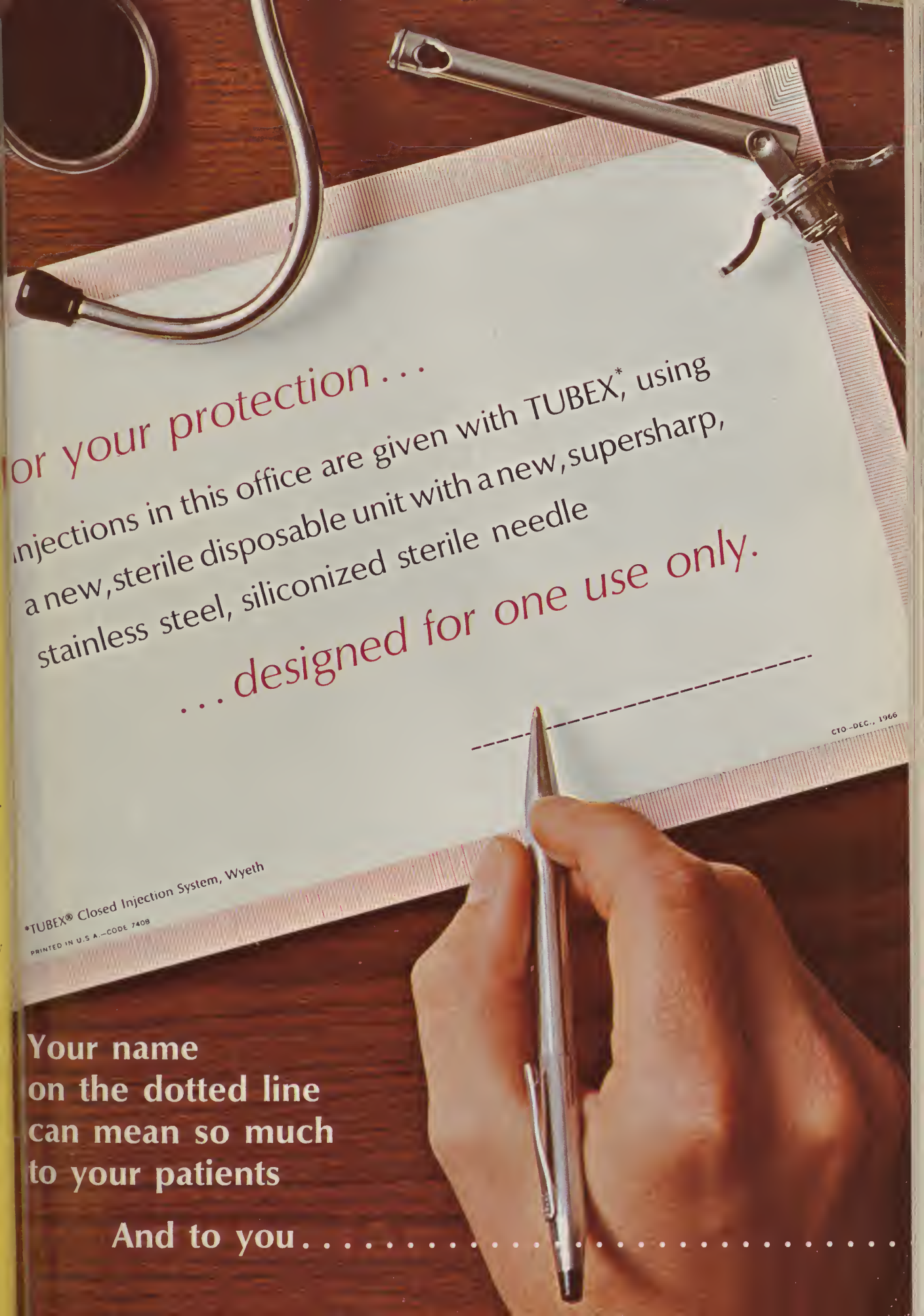
The AMA is also cooperating in establishing a qualified medical school in Viet Nam and has provided faculty, as well as financial and administrative help to accomplish this purpose.

VETERANS ADMINISTRATION FEES

Commencing July 1, 1967, the Veterans Administration will dispense with form-filling and make payments on the basis of Usual, Customary and Reasonable Fees to physicians who treat veterans under the Home Town Medical Care Program. Physicians should submit bills on their own billhead and it is no longer necessary to complete VA forms, the procedure required previously.

John Sargeant

Executive Secretary


or your protection . . .
njections in this office are given with TUBEX*, using
a new, sterile disposable unit with a new, supersharp,
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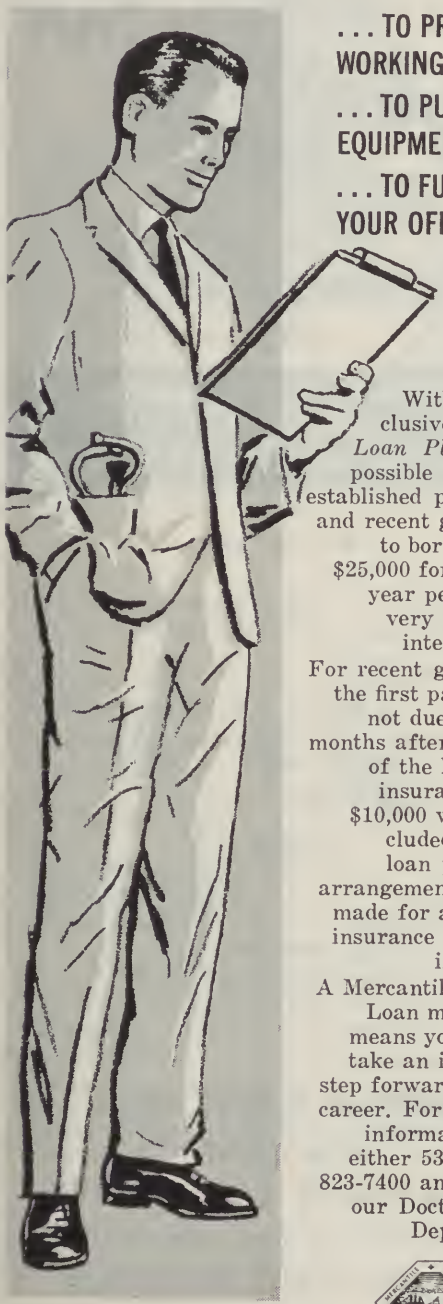
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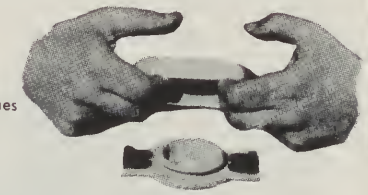
Best suited for centrally located stomas.

INSTRUCTIONS

Insert fingers into pouch opening and extend sufficiently to secure over Body Shield flange.

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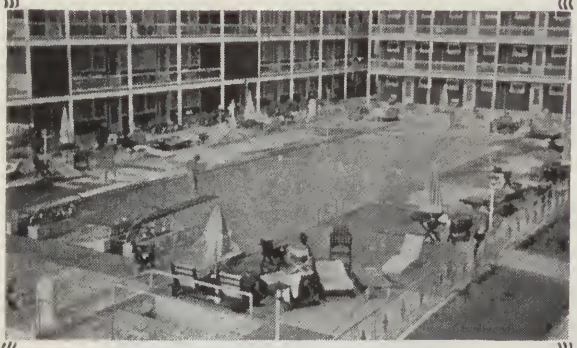
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PROGRAM OCEAN CITY MEETING

MEDICAL AND CHIRURGICAL FACULTY

FRIDAY, SEPTEMBER 8, 1967

9:30 A.M.

House of Delegates Meeting

All members of the Faculty are invited to attend

9:30 A.M.

Woman's Auxiliary Meeting

1:00 P.M.

Principal Nursing Home Physicians Luncheon Meeting

1:30 P.M.

Maryland Ophthalmological Society Meeting

2:00 P.M.

Maryland Society for the Rheumatic Diseases Meeting

6:30 P.M.

Social Hour at Poolside

Cocktails, hors d'oeuvres, and music

7:30 P.M.

BANQUET

After dinner speaker will be U. S. Congressman Eugene J. Keogh, Author of the HR-10 Self-Employed Retirement Act. A discussion of interest to all physicians and their wives!

WATCH FOR YOUR PROGRAM

All members of the Faculty will receive a detailed program in August. Upon request, a program will be sent to other interested persons.

SATURDAY, SEPTEMBER 9, 1967

9:00 A.M.

College of Surgeons Meeting

Business and scientific sessions

9:00 A.M.

Maryland Society of Pathologists Meeting

10:00 A.M.

Maryland Diabetes Association Meeting

11:00 A.M.

Maryland Psychiatric Society Meeting

1:00 P.M.

CRAB FEAST LUNCHEON

Phillips Crab House

Make your reservations *NOW* by writing directly to the Diplomat Motor Hotel

DIPLOMAT MOTOR HOTEL

Boardwalk at 26th Street, Ocean City, Maryland

Name .....

Address ..... Street ..... City ..... State

Please reserve ..... Bedroom(s) ..... Efficiency Unit(s) ..... No. persons

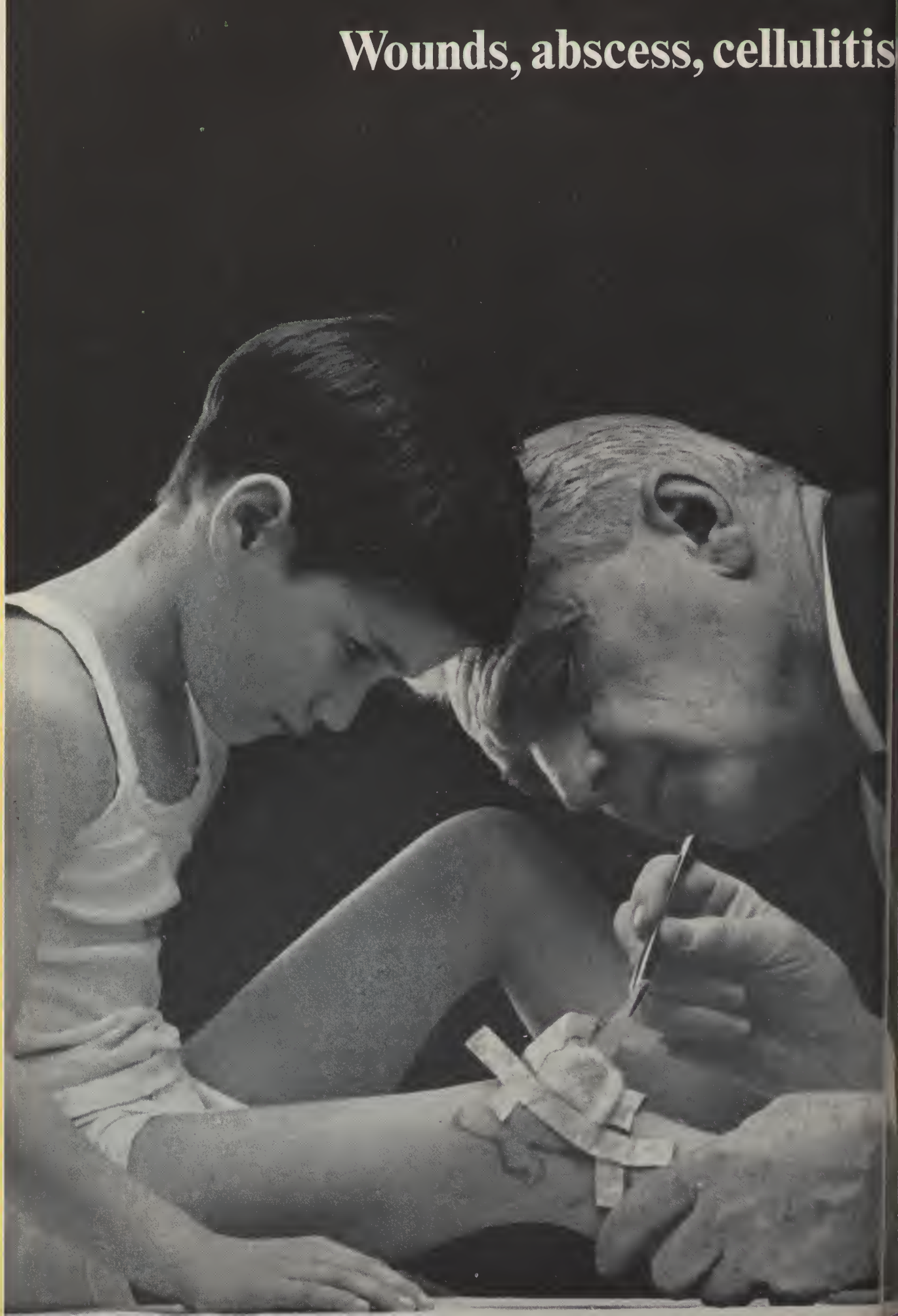
Date of Arrival ..... Date of Departure .....

Deposit of one night's rental required. All requests subject to confirmation. Convention Rate: European Plan—$16 per day for two persons for bedroom or efficiency. $2 per day for each additional person.

RESERVATION ASSIGNED IN ORDER RECEIVED

For your convenience, use the reservation form.

Wounds, abscess, cellulitis



...and the complications of staph.

From time of birth, the child is exposed to a whole range of potential staph infections: wounds; secondarily infected dermatoses; primary lesions, such as deep impetigo (ecthyma), boils and felons; and more serious conditions such as osteomyelitis, staph pneumonia and staph meningitis.

Bactericidal

Hardly a staph organism can resist the bactericidal action of Prostaphlin® (sodium oxacillin), as shown by a 34-month *in vitro* study. Of all staph isolates tested, 99.5% were sensitive to oxacillin.[1]

Clinically Proven

There is a high correlation between these *in vitro* findings and clinical results. Of 610 patients treated with Prostaphlin (sodium oxacillin), 89.8% were reported cured or improved, including those with staph infections resistant to penicillin G.[2] And since resistance does not appear to develop *in vivo,* therapy with oxacillin can be extended when necessary.

Outstanding Safety Record

Besides being staph-specific and rapidly absorbed—Prostaphlin (sodium oxacillin) has established an outstanding record of safety during five years of widespread clinical use. Continuous high blood levels of oxacillin have not produced toxic effects on kidney function, assuring a significant margin of safety. However, as with all penicillins, the possibility of allergic response should be considered.

Capsules, Oral Suspension and Injectable

Prostaphlin (sodium oxacillin) is available in three flexible dosage forms to suit the age of the patient and severity of infection—an oral solution for pediatric use, capsules, and multi-dose vials for injection.

PRESCRIBING INFORMATION: For complete information, consult Official Package Circular. *Indications:* Infections caused by Staphylococci, particularly those due to penicillin G-resistant Staphylococci. *Contraindications:* A history of severe allergic reactions to penicillin. *Precautions:* Typical penicillin-allergic reactions may occur. Safety for use in pregnancy and premature infants is not established. Because of limited experience, use cautiously and evaluate organ system function frequently in neonates. Mycotic or bacterial superinfections may occur. Assess renal, hematopoietic and hepatic function intermittently during long-term therapy. *Adverse Reactions:* Skin rashes, pruritus, urticaria, eosinophilia, nausea, vomiting, diarrhea, fever and occasional anaphylaxis. Rare cases of reversible hepatocellular dysfunction have occurred. Moderate SGOT elevations have been noted. Thrombophlebitis has occurred occasionally during intravenous therapy and leukopenia was noted in two cases. *Usual Oral Dosage:* Adults: 500 mg. *q.* 4 or *q.* 6 *h.* Children: 50 mg./Kg./day. *Usual Parenteral Dosage:* Adults: 250-500 mg. *q.* 4 or *q.* 6 *h.* Children: 50 mg./Kg./day. Treat beta-hemolytic streptococcal infections for at least 10 days. Give oral drug 1 to 2 hours before meals. *Supplied:* Capsules—250 and 500 mg. in bottles of 48. Injectable—250 mg., 500 mg., and 1 Gm. dry filled vial for I.M./I.V. use. For Oral Solution—100 ml. bottle, 250 mg./5 ml. when reconstituted. **A.H.F.S. CATEGORY 8:12.16**

References: 1. Abstracted from *Antibiotic Sensitivity of Staphylococci Studied from November 1962 through August 1965,* reported by Griffith, L.J., Staphylococcus Reference Laboratory, V.A. Hospital, Batavia, N.Y. 2. Data on file, Bristol Laboratories.

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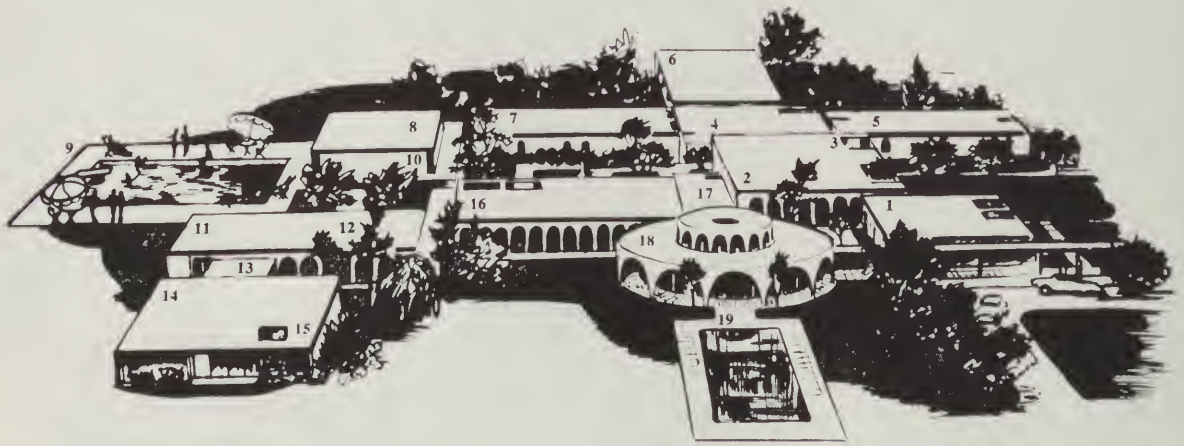
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8. Auditorium; Gymnasium
9. Swimming Pool Area
10. Exercise Room and Sauna
11. Open Cottage
12. Group Therapy Lounge
13. Nurses Station
14. Open Cottage
15. Fireside and TV Lounge
16. Occupational Therapy, Library
17. Connecting Passage and Offices
18. Gift Shop; Reception Area
19. Reflecting Pool

We are anticipating having our new Center ready for occupancy by mid-summer. This Center will have 60 additional rooms, each with private bath, that will augment our present 100-bed psychiatric facility.

All accepted modern therapies are employed, and not a day is wasted in placing a new patient on active treatment. Despite our increase in size, we will maintain the concentrated professional individual attention for each patient.

When the realization of this project is completed, we hope that the added staff and environment will create one of the finest centers for psychiatric treatment, not only in the East but in the country.

Edith L. Taylor
Executive Director

IRVING J. TAYLOR, M.D.
MEDICAL DIRECTOR

SEMINAR ON THE MEDICAL ASPECTS OF SPORTS

Monday, August 14, 1967

Catonsville Community College

(air conditioned facilities)

Ramsey B. Thomas, M.D., Chairman of Arrangements, Presiding

9:30 a.m.—REGISTRATION—COFFEE

10:00 a.m.—OPENING REMARKS

John B. De Hoff, M.D., Chairman, Subcommittee on the Medical Aspects of Sports of the Medical and Chirurgical Faculty

Oliver Laine, Ph.D., President, Catonsville Community College

10:20 a.m.—HEAT PROBLEMS

Herman C. Maganzini, M.D., Rockville

10:50 a.m.—QUESTIONS AND ANSWERS

11.00 a.m.—INTERMISSION—VISIT EXHIBITS

11:15 a.m.—FIELD DIAGNOSIS

G. Overton Himmelwright, M.D., Cumberland

11:45 a.m.—QUESTIONS AND ANSWERS

12 Noon —LUNCHEON

1:30 p.m.—HEAD AND NECK INJURIES

Neal I. Aronson, M.D., Baltimore

2:00 p.m.—KNEE AND ANKLE INJURIES

G. Edward Reahl, Jr., M.D., Baltimore

2:30 p.m.—QUESTIONS AND ANSWERS

2:45 p.m.—INTERMISSION—VISIT EXHIBITS

3:00 p.m.—TAPING CLINIC—KNEE AND ANKLE

Mr. Albert J. Battaglia, Trainer for Batimore Bays Soccer Team

3:30 p.m.—QUESTIONS AND ANSWERS

3:45 p.m.—CLOSING REMARKS

Richard D. Bauer, M.D., President, Medical and Chirurgical Faculty

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Mr. John Manley, Chairman, Division of Health, Physical Education, and Recreation, Catonsville Community College

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Registration and Luncheon $3.00

Your MEDICAL FACULTY at Work

JOHN SARGEANT EXECUTIVE SECRETARY

On Thursday, June 8, 1967, the Council took the following actions:

1. Adopted Council and Executive Committee minutes.

2. Ratified legal defense for seven physicians requesting it.

3. Considered a request for legal defense for a physician who had been late in paying his dues; but denied it, offering the services of a "medical panel" only.

4. Declined to provide legal defense, in the event of a suit, for two physicians who had been late in paying 1967 dues.

5. Authorized the Treasurer to adequately inform members when 1968 dues are payable they are not entitled to this provision of membership if dues are not paid before January 31. Notices will be carried in the November, December and January issues of the Journal and other educational measures will be used.

6. Heard of the settlement of two cases, both in favor of the defendant, and authorized payment of legal fees in this connection.

7. Remitted 1967 dues for a member because of illness and at the request of the component society.

8. Adopted the Financial Statement through April 30; and the Dedicated Fund Statement through April 30.

9. Instructed the Secretary to mail to all Delegates and Components the proposed Medical Practice Act change dealing with the establishment of a Commission on Medical Discipline so that it can be discussed adequately on a local level before final action at the Semi-annual Session in September.

10. Declined to mail to Components the comments of the Board of Medical Examiners on this proposed change, stating that the Board could do so itself.

11. Heard that the Crisfield Hospital administration has been turned back to the Board of Trustees by the Arbitration Committee set up for purposes of discussing this matter in detail.

12. Rejected a proposal from the MEDS Committee that would have established a special committee to look into the use of hospital emergency rooms as a substitute for the family doctor. It pointed out that many studies in this area had already been done; and that this was a local problem.

13. Approved advising the Maryland Pharmaceutical Association that it is the responsibility of the physician to write and refill Rx orders; and that its suggestion for individual physicians to delegate this authority to his office aide was not clear as to procedure and authority.

14. Approved the report of the PL 89-97 Subcommittee with respect to payment mechanisms for Third Party Payments under this program. (See separate item in this connection).

15. Approved a Joint Statement (with the Maryland Nurses Association) on the Role of the Registered Nurse in Care of the Patient with Cardiovascular Diseases. (to be published as a supplement to the Nurses' Protocol approved in June, 1965).

16. Adopted a report dealing with Appalachia Regional Medical Needs, a copy of which appears at the end of this summary.

17. Deferred action on a proposed Membership Retirement Program at the request of the Med-Chi Insurance Trust.

18. Approved a recommendation to the Mediation Committee as follows:

"That association with properly licensed Osteopaths (in accordance with appropriate statutes) is considered ethical in light of the law now permitting Maryland Osteopaths to practice Allopathic medicine."

19. Adopted the following in connection with the Title 19 program in Maryland:

"The medical profession wishes to go on record as supporting the concept of Title 19 but is unwilling in receiving state payments to continue its practice of subsidizing this program as in the past and will provide to the public the promised medical care only on a Usual, Customary and Reasonable fee basis."

"It was understood in adopting this motion, that authority is granted to appropriate Faculty representatives to meet with State officials to convey this information to them; and that the Executive Committee is authorized to contact the Federal Government in this connection to express its concern or unwillingness to participate in the program because of the manner in which it is being operated."

20. Heard that the Vocational Rehabilitation Program, operated through the State Department of Education is paying for care under this program on the basis of Usual, Customary and Reasonable Fees.

21. Adopted the following recommendations in connection with Alcoholism: (a) That the Faculty endorses a three day workshop on Alcoholism Programming for Public Health Professionals to be held on November 27, 28, and 29, 1967, and that Doctor Conrad Acton be appointed to serve as the Faculty representative to the program planning committee. (b) That the Medical and Chirurgical Faculty support the Alcoholism Control Bill proposed by Senators Javits and Moss, now under discussion in the Labor and Public Welfare Committee of the United States Senate.

22. Adopted the following recommendations in connection with the Aging: (a) That the Faculty support, where need is demonstrated, community sponsored nursing home facilities in all communities in Maryland for extended care, nursing home care, and custodial or

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domiciliary care. (b) That each local Commission on Aging stimulate activity in programing community sponsored nursing homes.

23. Adopted the following recommendation in connection with MEDIC: That the Committee on Postgraduate Education, Preventive Medicine, and Public Health strongly recommends that the present system of financing the MEDIC network on a local level as it now exists be continued.

24. Appropriated $3,000 from the Educational Fund, to be matched by a $3,000 sum raised by the Ophthalmologists, for the purposes of an educational program on eye care. It is understood that the program will be statewide and that funds will not be used for legislative purposes.

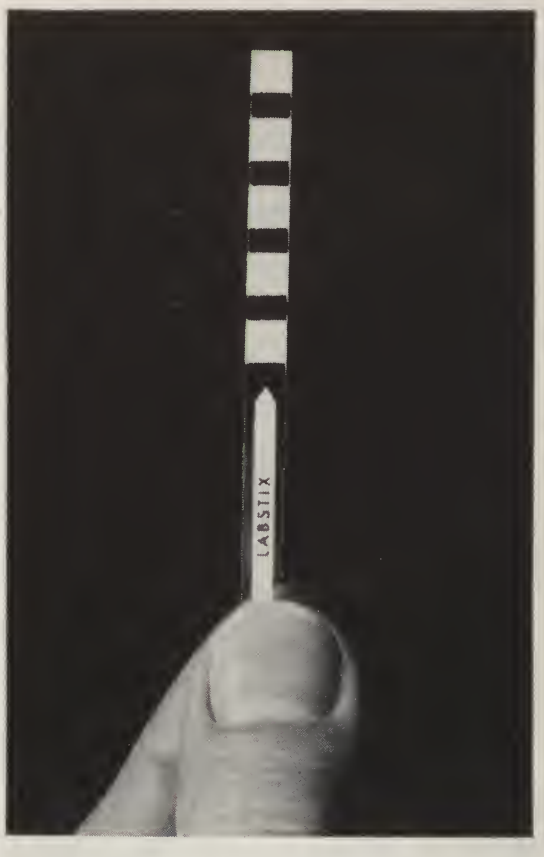
25. Adopted the following recommendation in connection with the Handicapped Children's Program in Maryland: The Medical and Chirurgical Faculty of Maryland reiterates its support of the high standards of care offered through the State Crippled Children's Program, which stands ready to accept handicapped children particularly where special facilities are needed and are available for treatment. It also reiterates the concept that the Crippled Children's Program continue to maintain contact with the referring family physician and that encouragement be given to him for his participation in the follow-up and after-care of such patients. The Medical and Chirurgical Faculty also goes on record as endorsing the continuance of the high standards that have been adopted and used in the operation of the State Crippled Children's Program.

26. Voted to recommend to the House of Delegates Emeritus Membership for Napolean B. Steward, MD, Laurel; at the request of the Prince George's County Medical Society.

27. Heard that the Executive Committees of the Prince George's County and Montgomery County Medical Societies had gone on record as urging the Faculty to proceed with its application for a Construction Grant under the Medical Library Assistance Act.

Report of the PL 89-97 Liaison Subcommittee to the Council adopted, June 8, 1967

The PL 89-97 Liaison Subcommittee was



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charged with the following by the Council on January 19, 1967.

"It is the consensus of the Council that this question be referred to the PL 89-97 Subcommittee and act as a basis of its discussion with the State Health Department and others involved with the following understandings:

1. Physicians must be reimbursed for care of so-called "service" patients;
2. The type of reimbursement can be based on a fee for service concept or a per diem concept, as outlined in the presentation by Dr. Nelson;
3. That some arrangements should be made for payment of the physician on a direct basis rather than channeling funds for payment through a third-party person, such as a hospital.

"The PL 89-97 Subcommittee, after study, will make its report with recommendations, preferably to the next Council meeting; but in any event prior to July 1, 1967."

The Liaison Subcommittee met on the evening of February 20, 1967 and after considerable discussion of this resolution adopted the following recommendation for submission to the Council:

1. More than one acceptable arrangement can be made between a hospital and a physician for payment of the physician for his activities in relation to "service" patients.
   These activities may fall into any of the following categories: (a) the direct supervision of residents or interns in the provision of services to Title 18 and 19 program patients (b) the direct provision of services to such patients (c) the direct or indirect responsibility of the physician for the care that is provided to such patients (d) the attendance, in person, of the physician as a teacher along with the resident who actually performs the service. Such activities, however, are not limited to these categories.
2. The physician and the hospital involved may work out arrangements suitable to them and approved by the medical staff.
   Such arrangements may include, but are not limited to: (a) a fee for service arrangement that provides for payment directly to the physician by the third party involved (b) a fee for service arrangement that

provides for payment to an association of physicians by the third party involved.

3. All arrangements should cover services whether rendered as an inpatient or an outpatient at the hospital concerned.
4. In all cases, arrangements should be those that will stand the test of "audit," by any party involved.

Report on Appalachia Regional Medical Needs

1. The extension of medical and paramedical educational facilities in all parts of Appalachia shall be actively encouraged, with improvement of local facilities now in operation, whenever feasible.
2. Rather than expend large sums of money for the construction of larger demonstration health centers, adequate funds should be made available for the addition to and enhancement of local county facilities already in operation. These facilities may be single or multi-county in operation.
3. The boundary lines between any of the Appalachian states shall not bar any citizen from seeking health care from a health center near his place of residence.
4. We strongly recommend additional funds under the Hill-Burton Act or other acts for increased construction of health facilities under Section 214 of the Appalachia Development Act.
5. Approval by organized medicine at national, state, or local level for the construction and operation of regional or community health centers shall be contingent upon acceptance and maintenance of the following conditions:
   (a) The operation of any regional or county health service center shall not infringe upon the private practice of medicine.
   (b) There shall be adequate medical representation on all national, state or local bodies having supervision or jurisdiction in the development and operation of these health service projects.
   (c) These projects shall in no way be developed, operated or influenced in a manner which could lead to a government-controlled system of medical practice.
6. The American Medical Association, through its cognizant Councils or Committees, shall be kept advised of all matters associated with the projects under discussion, and further, we request the American Medical Association to take all steps necessary for setting policies pertaining to these projects, as they may be concerned at the national level.



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Editorial

Much has been said, both pro and con, with respect to Generic Equivalents in the drug field. For some reason, the term "generic" has become associated with the word "cheaper," in its connotation to the public. The U. S. Congress is presently conducting hearings on this particular subject and has heard reports and arguments from proponents of the "generic" prescribing philosophy. This philosophy would establish a regulation that all drugs paid for in whole or in part by the Federal government must be prescribed under "generic" terminology.

One of the main reasons for such a regulation, argue the proponents, is that the Federal government purchases drugs by generic names and such drugs are used in treatment given at the major military installations of the country, such as the Walter Reed Army Hospital, Bethesda Naval Hospital, and others.

In actual fact, however, this is not so. The Department of Defense, which buys drugs for all the armed services, buys them according to rigid, quality-oriented specifications. It conducts a most rigid inspection and testing program. It rejects many of the companies that ask to do business with it.

What then, does it buy? It buys from the same quality-oriented firms, large and small, that are relied upon by the private practitioner.

In addition, Defense requires potential contractors to submit samples of their products before the contract is awarded and again there is a substantial rejection rate because of high standards. However, the manufacturer who fails a defense department inspection is still free to continue producing goods for the civilian market.

The new commissioner of the Food and Drug Administration, James L. Goddard, MD, has several times exploded this myth, also. In an interview conducted by the *Pharmacist's Management Journal,* this past March, he had the following to say:

> "I think it's going to require very careful study before anyone could assume that there is such a thing as generic equivalency on a broad scale in our drug field today. There will have to be better methods of determination of equivalency than we now have, and more attention to the entire problem. It's not a simple issue. We appreciate this."

In the same testimony given before a Senate Subcommittee the following examples of Department of Defense experiences with drugs of supposed generic equivalency were presented. It is important to note that these are some of the "bargains" that are frequently mentioned as being "saviors of the consumer's pocketbook."

- On 15 September 1961, the commanding officer of the U. S. Naval Hospital, San Diego, California, reported that his neurology department had received "many valid complaints of toxicity and lack of potency regarding this drug—*Diphenylhydantoin Sodium Capsules,* made by company A, and sold by company B. Complaints included increase in seizure (the drug is used primarily for the control of epilepsy), dizziness and drowsiness. The patients were mostly children.

- March 20, 1962, the Fitzsimmons General Hospital, Denver, Colo., reported that "recently several patients at Fitzsimmons General Hospital who have convulsive disorders have had onset of break-through of their seizures, and each individual stated that they wondered whether the medication was not involved, since they had been seizure-free for several years with Parke-Davis *Dilantin* capsules with the red band, but recently had obtained medication without the red band. Medication was given of Parke-Davis *Dilantin* and no seizures have re-



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.



curred." The report went on to say, "It is recommended that standardized Parke-Davis *Dilantin* be obtained in order to eliminate the disorders." The generic product had been supplied by Company B, and Company C.

• August 7, 1963, the U. S. Naval Hospital, Oakland, California reported that *Diphenylhydantoin Sodium Capsules* produced by Company D caused "the controlled seizure patient to unnecessarily become non-controlled, which is both physiologically and psychologically contraindicated; absorption from the gastro-intestinal tracts of patients has been spotty when this product is used."

• November 30, 1965, the Naval Hospital at St. Albans, New York reported still another series of unsatisfactory experiences with this drug, again from Company D. The neurologist "has had seven adult patients with increased epileptic seizures. . . . This drug is intended to be an anticonvulsant and is not producing the effect needed," the report added.

Interestingly, the lot of this product had passed tests in the military laboratory; samples sent to the *FDA* also seemed to be satisfactory.

• June 9, 1966, Dow Air Force Base, Maine, physicians submitted a complaint about a new lot of *Diphenylhydantoin* from Company D. "Patients on this drug are experiencing seizures more frequently than on previously available products," they said.

One firm supplied an antibiotic used in urinary tract infections (*Methanamine Mandelate Enteric*-Coated Tablets), but the product would *NOT* disintegrate. Laboratory tests and x-rays showed the tablets would not dissolve, and hence could not release the medication. When the defense department informed the firm, its response was that the patient be told to bite them in half and swallow the pieces.

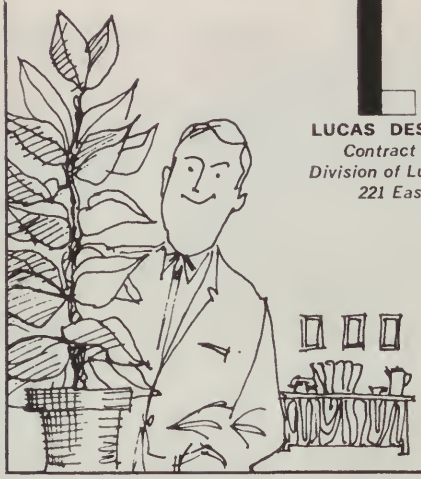
In 1964, the military submitted a number of versions of supposedly equivalent *Tetracycline* tablets for clinical testing to determine if the various firms' products actually got into the bloodstream. August 24, 1964, the laboratory reported that tablets supplied by Company E "gave no measurable blood levels in 7 of the 10 (human) subjects" who were given the product.

One additional example. *Nitrofurantoin* is a

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widely-used agent against infections of the urinary tract. Often, patients with chronic infections require this drug over extended periods of time. Defense department doctors and hospitals use it in substantial quantities, as do their civilian counterparts. A series of complaints came in on a supposedly generic equivalent to *Nitrofurantoin* supplied by an Italian firm, Zambon, S.P.A., beginning in 1961 and running through April 1963.

From military hospitals all over the country the word was the same: This *Nitrofurantoin* is unsatisfactory. From Walter Reed, evidence that it "almost invariably" caused nausea and vomiting. From Sheppard Air Force Base, Texas, reports of severe rash. Other reports came from military institutions in Virginia, California, Texas, Florida, Washington, Massachusetts, South Carolina, Maryland.

From the Naval Hospital at San Diego, there were detailed reports on a 15 year old female patient whose condition worsened to near death using this product.

Regarding the last case cited, the hospital's commanding officer made a comment of particular import to the point we are examining. He said, "It is felt that this (young dependent child's) life was jeopardized by *SUBSTITUTING AN UNKNOWN PRODUCT* for one which for several years had controlled her infection exceptionally well. The cost of two hospitalizations, plus the expensive *Coly-Mycin* (an antibiotic used against severe infections) and the transfusions, made the substitution in her case of *Zambon Nitrofurantoin* a very expensive maneuver."

I should add that the product that had helped this young girl well in the past, and which helped her recover her health when she was given it again, was a brand of *Nitrofurantoin* made by a small but highly-reputed firm, Eaton Laboratories.

These examples are why the Department of Defense in the future is going to require "evidence of effectiveness in human beings," before a company can qualify to supply it with a given drug. It is well that our physicians note this and continue to place their reliance on prescribing drugs they know, personally, will effectively treat the condition for which they are prescribed.

Tandearil®
oxyphenbutazone

Therapeutic Effects: Tandearil is a nonhormonal compound which may rapidly resolve inflammation and help restore normal joint function. Its action does not affect pituitary-adrenal function or impair immune responses. Its value in osteoarthritis is especially noteworthy because this disorder responds inconsistently to steroids and is often resistant to salicylates. Further, indomethacin is limited only to osteoarthritis of the hip, whereas oxyphenbutazone is effective in all forms of the disease.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: The initial daily dosage in adults is 300-600 mg. in divided daily doses. When improvement occurs, dosage should be decreased to the minimum effective level; this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

For complete details, please refer to full prescribing information. 6562-VI(B)R

Availability: Tablets of 100 mg.

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Geigy

Tandearil®
oxyphenbutazone

helps osteoarthritic joints move again



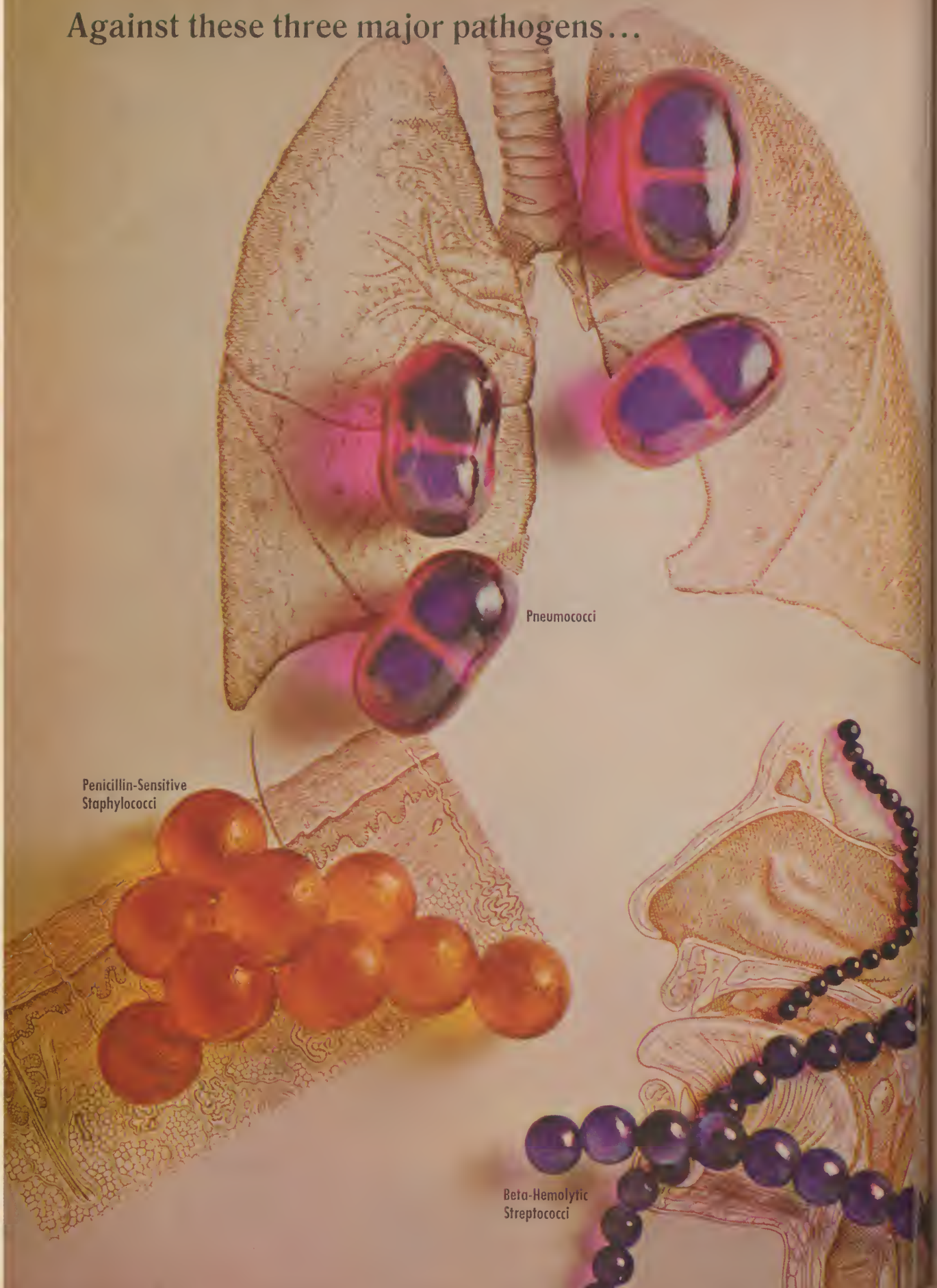
3 out of 4 osteoarthritics completely or markedly improved

Sperling, I.L.: 3 Years' Experience with Oxyphenbutazone in the Treatment of Rheumatic Disorders, Applied Therapeutics 6:117, 1964.	76.9% of 407 patients
Watts, T.W., Jr.: Treatment of Rheumatoid Disorders with Oxyphenbutazone, Clin. Med. 73:65, 1966.	84.6% of 39 patients

Please see adjoining page for brief prescribing summary.

TA-4919 PC

Against these three major pathogens...



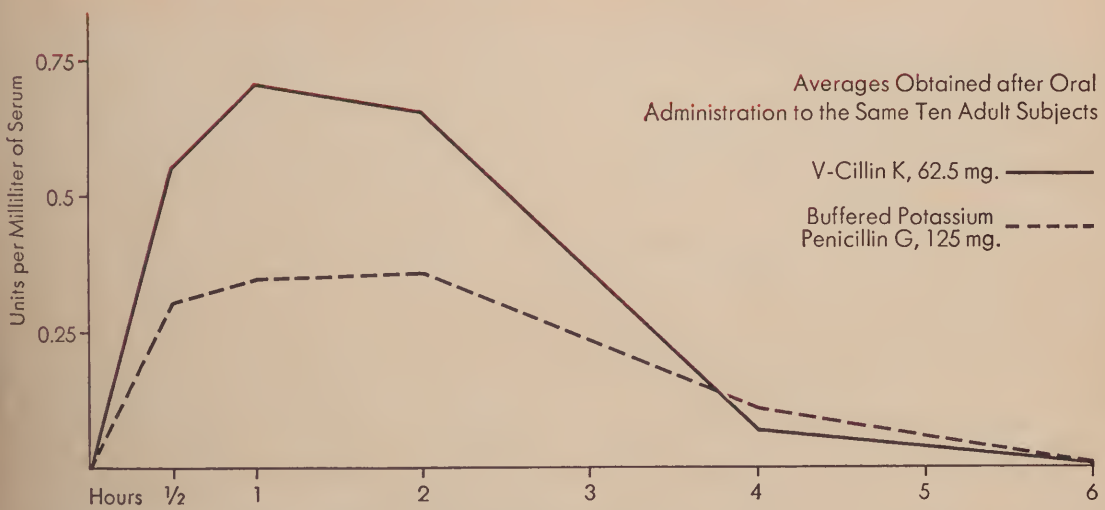
V-Cillin K® provides dependable oral antibacterial activity

because it combines a high degree of in-vitro activity...

Antibiotic	Staph. Aureus (Penicillin-Sensitive) MIC (mcg./ml.) Median	Range	Streptococcus, Group A MIC (mcg./ml.) Median	Range	Diplococcus Pneumoniae MIC (mcg./ml.) Median	Range
Penicillin V	0.02	0.02-0.04	0.02	0.003-0.4	0.01	0.005-0.2
Penicillin G	0.02	0.005-1.6	0.005	0.002-0.2	0.02	0.01-0.1
Methicillin	1.6	0.4-6.3	0.2	0.1-0.4	0.2	0.1-1.6
Oxacillin	0.4	0.1-3.1	0.04	0.02-0.4	0.1	0.04-0.8
Cloxacillin	0.2	0.2-0.8	0.1	0.1-0.8	—	—
Nafcillin	0.4	0.2-0.8	0.04	0.02-0.1	0.02	0.02-0.2
Ampicillin	0.2	0.1-0.8	0.02	0.01-0.04	0.02	0.01-0.04

Adapted from Klein, J. O., and Finland, M.: New England J. Med., 269:1019, 1963.

with high blood levels, even in the presence of food



Adapted from Griffith, R. S., and Block, H. R.: Current Ther. Res., 6:253, 1964.

V-Cillin K® Lilly 700636

Potassium Phenoxymethyl Penicillin

(See next page for prescribing information)

New 500 mg. tablets...a more convenient way to give high doses



Description: V-Cillin K is the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly). This chemically improved form combines acid stability with immediate solubility and rapid absorption. Higher serum levels are obtained more rapidly with this penicillin than with equal oral doses of penicillin G. The higher serum levels and acid stability of V-Cillin K make it a more dependable penicillin for oral use.

V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

Indications: V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Warnings: In rare instances, the use of penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin and in those with bronchial asthma or other allergies. Resuscitative drugs should be readily available for emergency administration. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for relief of immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly wit parenteral dosage schedules, frequent evaluation of the ren hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgr pencillin-insensitive organisms. In such cases, its administration be discontinued, and appropriate measures should be taken.

Adverse Reactions: Although serious allergic reactions are m common with administration of oral penicillin than with intran forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it does possess c cant index of sensitization. The following hypersensitivity r associated with the use of penicillin have been reported: ski ranging from maculopapular eruptions to exfoliative dermat caria; and reactions resembling serum sickness, including chil edema, arthralgia, and prostration. Severe and often fatal anc has occurred (see Warnings). Hemolytic anemia, leukopenic bocytopenia, and nephropathy are rarely observed side-eff are usually associated with high parenteral dosage.

Administration and Dosage: For Tablets V-Cillin K and for V Pediatric, the usual dosage ranges from 125 mg. (200,000 uni times a day to 500 mg. (800,000 units) every four hours. Fo the daily dosage may be 50 mg. per Kg. of body weight div three doses.

Beta-hemolytic streptococcus infections without associa teremia may be treated with 200,000 to 400,0000 units thre day. Therapy should be continued for a minimum of ten days t development of rheumatic fever and/or other serious comp Dosage for routine streptococcus prophylaxis in patients with of rheumatic fever or congenital heart disease may be 200 once or twice daily. When such patients undergo tonsillecto extraction, or other minor surgery, the prophylactic dose s 500,000 units every six hours given two days prior to surger two days postoperatively. If oral medication is not feasible c of surgery, parenteral therapy should be considered. Mild ately severe pneumococcus pneumonia has been treated with 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more shoul every six to eight hours in conjunction with indicated surgi dures.

For gonorrhea in males, 500 mg. (800,000 units) every fou three doses may be employed; in females, 500 mg. every for six doses are recommended. Refractory infections general to a second treatment three to four days following comple first. Treatment of gonorrhea with severe complications individualized, with prolonged and intensive treatment. Pati suspected lesion of syphilis should have a dark-field exam fore receiving penicillin and monthly serologic tests for a r three months.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,00 bottles of 50 and 100; and 250 mg. (400,0000 units) ar (800,000 units), in bottles of 24 and 100.

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,00 5 cc. of solution, in 40, 80, and 150-cc.-size packages.

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

Maryland State Medical Journal
Vol. 16, No. 7
July, 1967

THE ADOLESCENT GOES TO A GYNECOLOGIST

ALLAN C. BARNES, MD
Department of Gynecology and Obstetrics
The Johns Hopkins University School of Medicine

My assignment is to speak in very broad, general and, indeed, almost philosophic terms about the adolescent visiting a gynecologist.

The thesis that there is no such thing as adolescent gynecology could be defended from the point of view of our contemporary gynecologic practice. Certain it is that the organic complaints of the adolescent period are but a small fraction of our daily practice. That enchanting time of experimentally inserting foreign bodies into the vagina has already passed (there are few things that will strike terror into the heart of a mother more than the sight of a melting red crayon emerging from a four-year-old vulva), and that period which contains the bulk of the adult gynecologic complaints has not yet arrived. Statistically our own figures would indicate that the most frequent complaints brought to our attention during these years are, in order of their frequency, pregnancy and the need for contraceptive advice, vaginal discharge, menstrual irregularity or dysmenorrhea, and trauma.

Now it would also perhaps be feasible to defend the thesis of the relative nonexistence of adolescent gynecology on the grounds that there is no such thing as adolescence. I have no intention of flying in the face of the topic of this evening's session, and I recognize full well the dictionary definition of adolescence as the period between puberty and adulthood. But there is eternally a danger of setting aside any position in life as being a unique portion, the danger lying in the fact that we might mistake its uniqueness for isolation and that we might forget the continuing spectrum of life in which no time can be isolated as being uninfluenced by what came before or what is to come after.

It's not just that the woman becomes what the adolescent has made her. It is also that the adolescent is what the child has made her. We so often hear that adolescence is the period when the girl adjusts to her sexual role, but this narrow view accentuates the tubular vision that I am at the moment protesting. Adolescence is a period of relatively rapid acquisition of the physical characteristics of the gender role. But whether these physical characteristics are accepted as badges to be worn proudly or stigmata to be endured has already been cast into the personality rather long before these years arrive.

If a gynecologist should become strictly a gynecologist for adolescents he would have difficulty in influencing these reactions whose pattern has been established so much earlier. I would not deny the existence of the adolescent period as much as to restress the continuum of our behavioral de-

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velopment. The gynecologist is concerned with preparation for adolescence. When an adolescent is brought to him as a patient he is not infrequently the victim of that preparation for adolescence which the child has already received.

Let me start with a phrase that I have just used and explore with you its meaning and its management: when an adolescent is brought to him as a patient.

May we for a moment, without diagnosing or prescribing specific complaints, discuss this medical episode and its attendant obligations. Three questions have preceded this visit, and three reactions ensue.

The first question is whether or not the girl will share with her parents the difficulties which form her chief complaint. This question is tied directly to the rebellion which constitutes one of the most conspicuous features of adolescence. If she does share her problem with her mother, the girl must give ground in her fight for separateness and return to a dependent relationship that she is struggling to terminate. On the other hand if she makes the decision not to discuss this problem with her mother, she is perhaps for the first time in her life attending a physician's office without the protection of an adult presence and she is trusting the physician to guard her secret. Either answer to this question is difficult for her to accept and prejudices her against this visit.

The second question revolves around whether or not the problem is worthy of a physician's visit or if it can be temporized with. In most instances, despite, for example, quite heavy menstrual bleeding, the initial reaction is to "wait and see." And this initial solution represents a departure from the medical practice of the preceding fifteen years, and is perhaps related to the third question which is whether or not the problem is primarily pediatric or gynecologic.

For most girls the visit to a gynecologist during adolescence is the first time that they have seen a doctor other than the familiar pediatrician who has "raised them," so to speak, and this perhaps contributes to the decision for temporization. The child who cries in the evening has in the past been reported exceedingly promptly to her pediatrician. But she is now replaced by the girl who has dysmenorrhea and is often managed with home remedies for a year before reporting to her doctor.

In addition there is a heightened reaction to her body and especially to its sexual areas, and not infrequently an overreaction to a genital dysfunction. And while we all accept the fact that no one likes to go to a gynecologist and that the examination involved is an unpleasant one, this reaction is particularly true when the patient is an adolescent.

The visit itself initially calls forth dual reactions: those of the patient towards her illness, and we are rather used to these; and those of the parents about the girl and her illness and the mythology of gynecologic diseases.

Let us take Dr. Hornick's view seriously and recognize the reactions of the doctor about his teen-age patient. No one of us regards disease in our reproductive tracts as we regard disease elsewhere. No woman considers her uterus and her gallbladder as being equivalent. And this special feeling is accentuated in the teen-age girl. Doubts about her physical development as a woman, a guilt about masturbation and her sexual phantasies, real or imagined fears about how much of her private life the examination will reveal: all of these contribute to her embarrassment and her confusion.

Then there is the reaction of the parents. Adolescence is difficult for everybody: the adolescent herself, her teachers, her sidlings, here parents—all have trouble coping with this process. This is often especially true for the parents, all of whose strength and sense of responsibility and tact are called into play when confronted with the emergence of a teen-age daughter. Adolescence in a daughter is the first obvious step towards departure from the home, towards marriage and a job. With the acquisition of what the mother may consider to be an adult-type disease, with going to a physician who is associated with adult complaints, a visible step is made towards this disruption of the intact family.

In addition to a general apprehension about the nature of the illness, mother may experience the sense of her role and her maternal usefulness being terminated. The maternal reaction as we see it in the office may cover a spectrum from something apparently akin to "I told you so," to the perhaps related, "You see being an adult isn't easy and now you're getting a taste of what I have been suffering all these years."

Finally there is the gynecologist's reaction. Nei-

ther the patient nor the doctor exists in a vacuum. This is a two-person relationship and each is reacting to the other. This is always true of course but with the teen-age patient it also represents three special problems.

First, the doctor gets the sensation of being caught between the girl and her family. And this is especially true if the issue concerns a request for contraceptive information or the revelation of a possible pregnancy.

Secondly, the doctor may feel himself caught between the girl and society, especially with respect to a pregnancy or abortion.

And, thirdly, the doctor may be caught by himself, either the memory of behavior during the same period of his life or his concept of himself currently and his community position and his own parenthood. Thus the gynecologist-obstetrician may be triply compromised in this position.

Now the therapeutic weapons which are customarily the armamentarium of gynecology and obstetrics are more subject to legal pronouncement and social taboo than are the therapeutic weapons of any other discipline in medicine. Legislators who would never dream of considering a law that specified which patients might receive insulin or in what doses will solemnly debate and even pass laws which prescribe what patients may or may not have the therapies which are familiarly employed by the gynecologist. And in addition to these laws there are strong feelings in the community about such things as venereal disease, virginity, extramarital pregnancy, and these feelings are often incorporated into professional ethics or customs. That these laws and these customs have little to do with the reality of contemporary life is an observation that is familiar to all of us. Nevertheless, the obstetrician-gynecologist often finds himself in the position of uncomfortable middleman.

No single set of procedures will unwind this situation and its many diverse elements. Some principles however emerge from a careful reevaluation of our own teen-age patients, their problems and their medical contacts concerning these problems.

The first of such principles is that the adolescent should be treated as an adult. Initially the girl should be conducted alone into the office for history taking. There are those obviously who would prefer to have the mother present, but this fact should be communicated to the doctor in the mother's absence. We have found that the majority of girls are perfectly competent to give a good history without the eternal coaching of a parent and there is no confusion as to who represents the physician's concern.

This admonition that the patient should be treated as an adult and that the history should be taken in confidence is not meant to imply that the personal management throughout should be the same as with an adult. The girl will need more reassurance and some indication that her own dislike for this session is shared by many including obviously the physician himself when he has to seek medical consultation. Nor is the momentary exclusion of the mother meant to imply that the history should in any way differ in its extent or in its coverage. Unduly intimate questions should be kept at a necessary minimum. Confidences should be shared much later when the youngster is more at home with this situation. And it should be remembered in this connection that silence is not simply a phenomenon designed to exasperate the doctor. Silence is a symptom which covers so many feelings that it should not evoke our annoyance but a careful exploration after more confidence has been obtained.

The history and the examination are carried out in other words with the same degree of privacy that would be accorded to an adult patient. Mother can join in a discussion of diagnosis or therapy, again with the permission of the patient, but this should not include a detailed recapitulation of the history in front of the historian. It is imperative to remember in this connection that the married teen-age patient should never have a mother substituted for the husband. He is the one with whom discussions should be held. The parents need general reassurance perhaps but he needs a recognition of his current responsibility.

The second principle is that the subject matter to be discussed should be taken casually. The physician is at all times a teacher and as such he should convey the fact that the perineum is just another part of the body. The reluctance of the adolescent to inspect her own perineum can be combatted by a matter-of-fact acceptance of her genital anatomy and this can be achieved best by the routineness of the office ritual.

The third principle which seems self-evident in

the extreme: examine the patient.

This obvious comment must be made because patients have been found with reasonably serious lesions the diagnosis of which has been delayed because the family physician was curiously reluctant to perform a pelvic examination. In a recent series of mixed mesodermal tumors reported from the Mayo Clinic, the patients under twenty-one years of age had a worse prognosis than the patients over twenty-one partially at least because all the cases of physician delay were in establishing the diagnosis in the younger age group.

This reluctance to examine the girl is often based on a fear of psychologic trauma, a concern that he would create a vaginal fixation. Hornick and Astradt have pointed to this fear and suggest that psychiatrists and analysts have been responsible for it. The psychologic aspect should not take precedence over the need for actual physical care. And most of these youngsters are smart enough to recognize either the obvious omission of an examination or an incomplete examination. If the mother thinks enough of the complaint to bring her daughter in, then the physician should think enough of it to examine the girl. Actually, a gynecologist's office is fundamentally for carrying out pelvic examinations. If any woman, whatever her age, gets inside that office she should have a thorough examination—and this even applies I might say to the lady who comes to collect for the Red Cross.

Finally, let us remember to examine ourselves. Being in a profession does not keep a physician from being human. In the midst of an afternoon of menopausal complaints and cancer detection comes a bright young thing who is obviously becoming a sexually alive person and is not infrequently sexually provocative. And perhaps the best admonition is that the physician not become self-conscious about having personal reactions. One finds on such self-examination that the tendency to retreat to parental roles and poses swings between being over-permissive and being overstrict, and perhaps in a positive sense the best suggestion is that one be reasonably consistent and always, always make clear to these girls the basis for your decision. If they can not be aborted or they can not receive contraceptive prescriptions, make sure that they know that this is because of a true and immutable law or because of the physician's cowardice or because of the physician's religious bias. Whatever the reason the girl has the right to know the basis for the decision. As we examine ourselves the results of this examination should where pertinent be shared with our patients.

Adolescence in the continuum of human development is a transition phase. Attitudes have to a great extent already been established but uncertainty is still there and apprehension about the adult role to be played lurks just underneath the surface. Dealing as we must with the biology of sex and reproduction, let nothing happen in this office visit to dampen the girl's enthusiasm for the adult feminine role.

I am not discussing the youngsters who emerge into adulthood accepting the feminine role. I am pleading for those who emerge with a positive pride in it. It is a wonderful thing to be a woman. And let's make sure our adolescent patients know this.

QUARTERLY ON CEREBROVASCULAR DISEASE PUBLISHED BY AMERICAN HEART ASSOCIATION

The Winter-Spring 1967 issue of STROKE—CURRENT CONCEPTS OF CEREBROVASCULAR DISEASE is now available to physicians, hospitals and medical schools without charge from local Heart Associations.

This is the first issue of the publications sponsored directly by the American Heart Association. The quarterly publication was established in 1966 and previously issued by the New York State Heart Assembly.

The publication, intended to offer interesting and practical information to the medical practitioner, will continue to carry one or two short, pertinent articles on the subject of stroke in each of its four issues a year. Walter J. Friedlander, M.D. of Omaha, remains as editor.

ENDOCRINE PROBLEMS OF THE ADOLESCENT

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In order to assess the endocrinological problems of the adolescent, some five years of histories were reviewed and the complaints of patients between the ages of twelve and twenty-one were analyzed.

Of 509 patients, 356 were thought to have complaints of an endocrinologic nature and these complaints could be categorized in five classes.

There were 188 patients seen because of amenorrhea or oligomenorrhea; 71 patients had irregularities or abnormalities of the menstrual flow; 57 had dysmenorrhea; 35 had hirsutism or acne; and 6 had problems of breast development, either hyper- or hypotrophic.

As the problems of ovulation and amenorrhea will be discussed by Dr. Howard Jones, I am going to devote the rest of the discussion to the diagnostic procedures used in order to make an etiologic diagnosis and a specific treatment regime in patients with menstrual irregularities.

Seventeen of the children who were seen had irregularities of such minor nature that only an examination and reassurance was required. It was believed that these patients presented themselves because of either parental overconcern or adolescent over-concern. Fifty-five however had excessive menstrual flow and required diagnostic procedures.

The first necessity is a careful history and physical examination, as has been previously emphasized. Ordinarily, except in those rare instances where the flow is not of such severity or has been present for such a short time—usually three months—a dilatation and curettage is advisable even in the adolescent patient. This procedure is itself not only diagnostic but frequently curative. In addition this is the first step towards separating dysfunctional bleeding due to anovulatory causes from that due to ovulatory causes.

If the bleeding is of such character that the patient can postpone a curettage for six weeks, it is frequently helpful to ask her to keep a basal temperature record. This is the simplest way to differentiate ovulatory from anovulatory bleeding.

A routine hematologic study should be a prerequisite. This includes a hematocrit, white count, differential, platelet count and sedimentation rate.

If the individual has not had a thorough physi-

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cal examination recently, this is also recommended. Ordinarily unless there are symptoms which warrant it, we do not feel it necessary to do an X-ray of the chest or tuberculin test. A protein bound iodine or a Column **T 4** test for thyroid function is usually indicated. A fasting blood sugar and if there is any evidence of excessive hair, a urinary 17-ketosteroid assay is requested. If there are any signs or symptoms suggestive of intracranial lesion, of course an X-ray of the sella turcica is necessary.

As far as the history is concerned, it is often extremely valuable, and if well taken can give one a clue to the etiology immediately. I try to take a history which gives the setting in which the menstrual irregularity has begun. Thus it is important to know if the menstrual irregularity has been present from the onset of menses. If it has a sudden onset it is extremely important to know if there has been an illness prior to the onset of the menstrual irregularities, if there has been an emotionally traumatic experience, if there has been a weight gain or loss. In my experience some of the most important findings from a psychological point of view has been a history of alcoholic parents, broken families, or love affairs.

As far as the history of weight gain or loss is concerned, a nutritional history is important. I take this by simply asking the patient's present weight, the average weight, the most she has ever weighed and the least she has weighed. If from this weight history in comparison to her height I believe that there may be a nutritional problem, I then ask the patient to keep a record of what she has had to eat and drink during the week before she comes in for her next visit.

The next thing of importance is the physical examination and this of course begins with the hymenal ring which can cause irregular intermenstrual bleeding. In addition to this one occasionally finds severe vaginitis responsible for a bloody type of discharge. Less common are cervical and endometrial polyps but these also can be present even in adolescent children; sarcoma botryoides, carcinoma of the fundus, most unusual, and finally tumors of the ovary which are associated with anovulatory dysfunctional bleeding. If the examination is unsatisfactory, it is wise to schedule the patient for an examination under anesthesia.

Having finished the history and physical examination, one must decide according to the severity of the bleeding whether or not one should start the patient on a basal temperature chart and decide on a curettage within the next four to six weeks. If in the month or six weeks the patient's menstrual bleeding continues in an irregular fashion, if the hematocrit is low to begin with or rapidly dropping, a curettage should be advised.

Among the 71 patients seen, 23 were thought to have mild menstrual dysfunctional bleeding due to psychogenic factors. Six had metabolic disease. These wese hypothyroidism in 2 patients, diabetes in 4. Four had nutritional disturbances which were probably on a psychogenic basis. Three had extreme weight loss: two because of their interest in various careers which required excessively thin individuals, ballerina and television; one was unusually stout, had been overweight her entire life but upon reaching adolescence had decided this was a social problem and that weight loss would be advantageous.

One patient had a tetralogy of Fallot and it has been our experience that this medical condition is often associated with abnormalities of steroidogenesis. Six patients had neurological disturbances, most being due to birth injuries which had apparently left scars in the central nervous system interfering with the hypothalamic-pituitary pathways. These patients have continued to have menstrual irregularities throughout treatment in the follow-up period. It is thought that continuous replacement therapy will be necessary to control these patients throughout their lives.

Six patients had primary ovarian problems. Two had ovarian tumors and four had polycystic ovaries associated with the Stein-Leventhal syndrome.

Six patients had mid-cycle bleeding which following a curettage was diagnosed as ovulatory bleeding. And two patients had severe Trichomonas vaginitis.

Thus it can be seen that the majority of the dysfunctional bleeding was associated with the anovulatory type, only 8 classifying as having ovulatory bleeding.

The classification of dysfunctional bleeding into anovulatory and ovulatory is of clinical value as, by and large, differentiates the functional endocrinologic types from the anatomical types. Patients who are bleeding with secretory endome-

trium are much more apt to have anatomical problems and should be considered in this category until proved otherwise. Although none of the patients in this group happened to show endometrial polyps, cervical polyps or blood dyscrasias, these do occur in adolescents and must be ruled out.

The importance of separating the ovulatory from the anovulatory types is also seen in the selection of therapy. The anovulatory or the endocrine dysfunctional bleeding will respond to substitution progestational therapy and the ovulatory will not respond to this form of endocrine substitution. Twenty-one of our 22 patients who were treated with progestational therapy responded with control of their abnormal menstrual bleeding. One patient did not respond and she was found to have a Stein-Leventhal syndrome and has been improved following wedge-resection operation.

While attempting to make an etiologic diagnosis for the anovulatory dysfunctional bleeding, we found it can be controlled satisfactorily with progestational therapy, and for many years we have used Ethisterone, 30 milligrams daily for five days given every twenty-eight days for three cycles. Therapy is then interrupted in order to allow the patient to revert to a normal cycle as this occurs spontaneously in about 60 percent of the cases. It is often helpful to keep the patient on a basal temperature chart, it is then easier to tell immediately whether or not ovulation has occurred. Provera, 10 mg a day for five days, given in a twenty-eight-day cyclic fashion is probably as satisfactory and if there is some doubt as to whether or not the patient will take oral medication 50 mg of Progesterone in oil intramuscularly every twenty-eight days usually will induce a regular bleeding period. It is always well to remember however that this is substitution therapy, not curative. It does not produce ovulation and one must continue to look for some specific cause of the anovulation which will respond to a specific therapy.

In addition to this type of substitution therapy we now have available Clomithene Citrate which will initiate ovulation in an anovulatory patient. This is particularly efficient in the group of patients who have dysfunctional bleeding with evidence of excessive estrogen. I would however believe that it might be best to reserve this therapy for those individuals who are interested in pregnancy and not to give it to adolescent patients unless it is given as a single therapeutic trial. Although the drug is a very interesting and important one, it has not been as satisfactory as we had hoped when it was first introduced, as it apparently does not actually cure the anovulation but must be taken repeatedly, also apparently as substitution therapy.

Experience with the use of estrogens in the control of menstrual anovulatory bleeding has been relatively poor and the same is true of the oral contraceptive pills which also contain estrogens. It is not well understood why a dysfunctional bleeding cycle can not be as readily controlled using these agents as it can be with Progesterone alone but this has been the clinical experience. If, however, one gives a high enough dosage of any of the progestational agents such as Norlutin, 10 mg daily over a period of twenty or twenty-five days, then it is possible sometimes to completely inhibit the hypothalamic-pituitary secretions and also to produce an atrophic type of endometrium so that bleeding may be inhibited. This form of therapy has been used by several investigators for the control of bleeding with blood dyscrasias. In other words, the patient can be started on medication and continued indefinitely so that the menstrual period never occurs.

Dysmenorrhea occurred in 57 patients in this series, and there is little new to be said as to the cause of dysmenorrhea. Most adolescents fall into the idiopathic category and this was true in the present series. Fifty-four were idiopathic. Only 3 showed anatomical problems. These 3 however were interesting. The oldest was nineteen, who had had severe dysmenorrhea since the age of fifteen and was found to have extensive endometriosis.

Another patient at the age of fourteen had just begun with her menstrual periods and in the past six months had had four periods, each one progressively more painful. The last one had been apparently extremely difficult. She came in with her mother who was very loath to let her come into the office by herself and because of this parent-child relationship I immediately thought that the problem was psychogenic due to an overanxious mother and a suggestive dysmenorrhea pattern. As she went into the examining

room I allowed the mother to come in to talk to me and she gave me exactly the history which I expected, that she had always had a terrible time with periods herself and that she had anticipated that her daughter would have this same problem and that she couldn't feel sorrier for her. I then went into the examining room expecting to do a rather cursory physical examination which would be completely normal and was startled to find a cyst the size of a grapefruit in the vaginal vault. Under anesthesia she was found to have a bicornute uterus with a blind horn and at operation this was corrected and the patient has had no more dysmenorrhea.

The third patient was a child brought in with a history again very suggestive of psychogenic amenorrhea in that she was an adopted child. Following her adoption the parents had three children of their own in rapid succession. In addition to this at the age of fourteen she had attained the height of six feet so she was obviously almost a foot taller than all of her peer group. In spite of this she seemed to be a very well adjusted child and in talking to the mother and the pediatrician they both informed me that they thought also that she had no psychogenic problems.

Under the circumstances because the dysmenorrhea was incapacitating, necessitating missing two days from school, it seemed important to immediately rule out a psychogenic factor and it was decided to stop the patient's ovulation. As demonstrated by Sturgis in 1940, if ovulation is interrupted no dysmenorrhea occurs. We therefore attempted to block ovulation in this patient by giving 10 mg of Enovid for twenty days in each cycle. Much to my surprise the patient continued to complain of dysmenorrhea in the withdrawal bleeding cycle which ensued. I was therefore again forced to consider psychogenic amenorrhea but because the mother seemed so sure that this could not be the case, we decided to schedule her for an examination under anesthesia and curettage. Much to my surprise a large endometrial polyp was present. Since the removal of this polyp there has been no more dysmenorrhea.

The obvious moral is that although most cases of dysmenorrhea in the adolescent are of idiopathic type with normal anatomical findings there is an occasional anatomical cause and each patient must be examined.

The medical treatment for dysmenorrhea is well known. Edrisal, Trasentine, Equagesic all have their place as well as aspirin and hot water bottles. When the condition is severe enough to warrant it, Duphaston, 15 mg daily for twenty days beginning on the fifth cycle day, has been an extremely satisfactory drug. It is the most conservative type of progestational agent as it usually can be given in amounts which are small enough not to interfere with ovulation but nevertheless will give relief from the dysmenorrhea. Occasionally one can reduce the dosage to 10 mg daily over a fifteen-day period. There were 23 patients in the present series with severe incapacitating dysmenorrhea who were treated with this medication satisfactorily. However the problem with it as with all other types of medication for dysmenorrhea is that once the medication is discontinued the dysmenorrhea is apt to return.

It seems well to begin the treatment of dysmenorrhea in the adolescent as rapidly as possible. If one can interrupt a habit pattern of this type sometimes one can cure the condition, but if it has gone on for any length of time it seems to have established a pattern which is very difficult to interrupt. Once the individual has been reassured that the pain be controlled and completely eliminated her pain with Duphaston, then she is often willing to endure with this if she does not have a specific obligation at the time of her menstrual periods. I therefore usually tell her to discontinue the medication unless looking, forward, find, that she has some important thing such as an examination, a piano or dance recital, or a prom to attend at the time of the menstruation. If this is the case then she takes her Duphaston in the period prior to this expected engagement.

It should be unnecessary to state that narcotics or any type of habit-forming drug such as alcohol should not be used in a chronic recurring medical condition such as dysmenorrhea.

GENERIC AND TRADE NAMES OF DRUGS

1 ENOVID: norethynodrel with mestranol
2 EDRISAL: amphetamine sulfate with aspirin
3 EQUAGESIC: meprobamate and elhoheplazine citrate with aspirin
4 NORLUTIN: norethindrone
5 PROVERA: medroxyprogesterone acetate
6 TRASENTINE: adiphenine

CONGENITAL ANOMALIES AS A CAUSE OF PRIMARY AMENORRHEA

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Congenital defects may be defined in a variety of ways. Most of us are apt to think of a congenital defect as a rather gross, easily diagnosable condition. However, a broader view would include more subtle problems, such as a single enzyme deficiency located in a critical area, the net effect of which is primary amenorrhea. A single enzymatic defect in the adrenal gland causing virilizing adrenal hyperplasia is an example of such a lesion. Viewed in this broader light almost all, but not all, cases of primary amenorrhea are indeed due to a congenital defect.

I have chosen to adopt the broader concept, for no other reason than when the patient presents herself with primary amenorrhea we do not have the advantage of knowing whether it is explainable by a gross anatomical abnormality and, therefore, the patient must be studied with the entire problem of primary amenorrhea in mind.

First, a word about when a work-up might be advised for a patient with primary amenorrhea. At what age is this to be undertaken? In my opinion, at least a careful history should be taken and a careful examination should be done when either the patient or her parents are sufficiently interested in this problem to seek medical advise.

If the history does not reveal similar symptoms in other members of the family and if the examination reveals that a vagina and uterus are present, the problem then arises as to how much additional work-up should be undertaken.

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Puberty is a complex phenomenon of maturation which involves many more things than the onset of menstruation, which is only the most obvious sign. If there are no signs of the initiation of puberty, such as the presence of axillary or pubic hair, or of breast development, there is certainly more urgency to the work-up and even at a rather early age; for example, fourteen—a work-up of considerable detail might be initiated. On the other hand, if the other signs of puberty are indeed present but menstruation has not started, some delay might be entertained with a working diagnosis of delayed puberty (a late bloomer). If, however, menstruation has not appeared by the age of 18, a very thorough work-up is then indicated regardless of how good the other signs of puberty may be.

A CLASSIFICATION OF AMENORRHEA

Amenorrhea may be discussed under four main headings—lesions of central origin, lesions of intermediate origin, lesions of gonadal origin and lesions of end organ origin (Table 1).

The diagnosis of 46 recent consecutive patients with primary amenorrhea according to the classification of Table 1 is shown in Table 2 (Table 2). An example of a patient from each main category will be discussed.

Table 1

CLASSIFICATION OF PRIMARY AMENORRHEA

I. Lesions of Central Origin
  A. Neurogenic
    1. Organic destructive lesion
    2. Idiopathic hypothalamic dysfunction (Stein-Leventhal Syndrome)
    3. Inhibition of the prolactin inhibition factor (Ahumada-del Castillio Syndrome)
    4. Idiopathic hypogonadotrophic eunuchoidism
  B. Pituitary Disturbances
    1. Tumors
      a. Chromophobe adenoma (Ahumada-del Castillio Syndrome)
  C. Psychogenic Amenorrhea
    1. Major and minor psychosis
    2. Emotional shock
    3. Anorexia nervosa
II. Lesions of Intermediate Origin
  A. Chronic Illness
  B. Metabolic Diseases
    1. Thyroid
      a. Hyperthyroidism and hypothyroidism
    2. Pancreas
      a. Diabetes mellitus
    3. Adrenal
      a. Congenital virilizing adrenal hyperplasia and related disturbances
      b. Cushing's disease and "stress obesity"
      c. Adrenal tumor
  C. Nutritional Disturbances
    1. Malnutrition
    2. Exogenous obesity
III. Lesions of Gonadal Origin
  A. Congenital Developmental Defects—Hermaphroditism and Related Conditions
    1. Gonadal agenesis (Turner's Syndrome and related conditions)
    2. Virilizing male hermaphroditism
    3. Feminizing male hermaphroditism (testicular feminization syndrome)
  B. Destructive Lesions—Infections, Neoplasms, Irradiations, Surgical Trauma, etc.
  C. Tumors
    1. Virilizing
    2. Feminizing
IV. End Organ
  A. Congenital Defects
    1. Imperforate hymen (cryptomenorrhea)
    2. Transverse vaginal septum (cryptomenorrhea)
    3. Absence of vagina and/or uterus
  B. Acquired
    1. Atresia of the vagina
    2. Atresia of the cervix
    3. Destruction of uterine cavity due to infection

Table 2

PRIMARY AMENORRHEA

I. Lesions of Central Origin	
Stein-Leventhal Syndrome	1
Pan Hypopituitarism	1
Ahumada-del Castillio Syndrome	2
Hypogonadotrophic Eunuchoidism	12
II. Lesions of Intermediate Origin	
Malnutrition	5
Adrenal Hyperplasia	2
Adrenal Tumor	1
Hypothyroidism	1
III. Lesions of Gonadal Origin	
Gonadal Agenesis	3
Male Hermaphroditism, feminizing	3
Male Hermaphroditism, masculinizing	2
Arrhenoblastoma	1
Hilus Cell Tumor	1
IV. End Organ	
Congenital Absence of the Uterus and Vagina	10
Infection (tuberculosis)	1
TOTAL	46

LESIONS OF CENTRAL ORIGIN

A 22 year old patient with primary amenorrhea who was referred with the comment that she had no ovaries. There was no history of breast development, but pubic and axillary hair in a scant amount had appeared at about the age of 12.

Physical examination showed that she weighed 120 pounds and was 5 feet 4 inches tall. There was no breast development, but rather sparse axillary and pubic hair. The external genitalia were normal but undeveloped. There was a small undeveloped vagina and on rectal examination a very small uterus could be felt (Fig. 1).

Laboratory studies showed that the buccal smear was 30% positive for sex chromatin. Chromosomes on the peripheral blood revealed 2 $\times$ sex chromosomes. The gonadotrophins were negative at less than 6.6 mouse units per 24 hrs. on 4 occasions. The PBI was 6.0 ug/100 ml. The 17-ketosteroids were 3.5 mg/24 hrs.; 17-hydroxycorticoids 5.2 mg/24 hrs. The maturation index was 95-5-0. Total estrogens were 7 ug/24 hrs.

These diagnostic findings ruled out ovarian agenesis and were consistent with the diagnosis of hypogonadotrophic eunuchoidism. This diagnosis was confirmed by the administration of human pituitary gonadotrophin 2 mg/day for 4 days followed by 3,000 units of HCG for 3 consecutive days. Following this a biphasic temperature chart

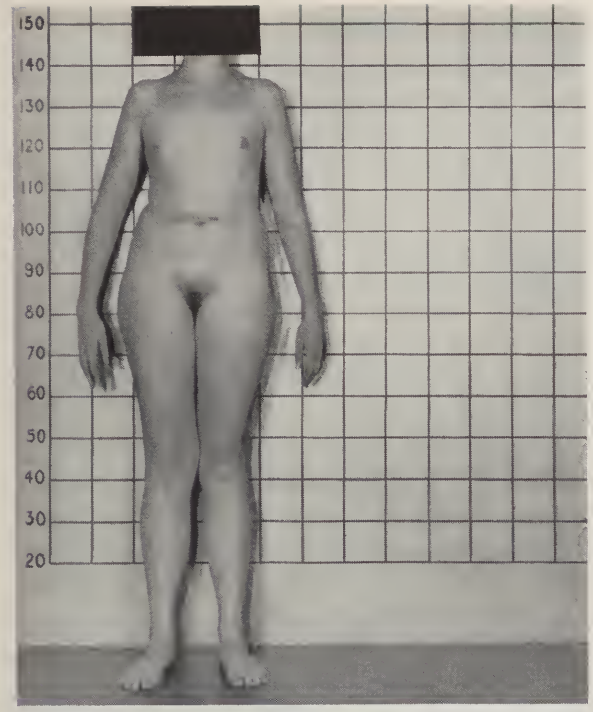


Figure 1

Photograph of 22 year old patient with primary amenorrhea. The only evidence of secondary sex development is pubic and axillary hair.

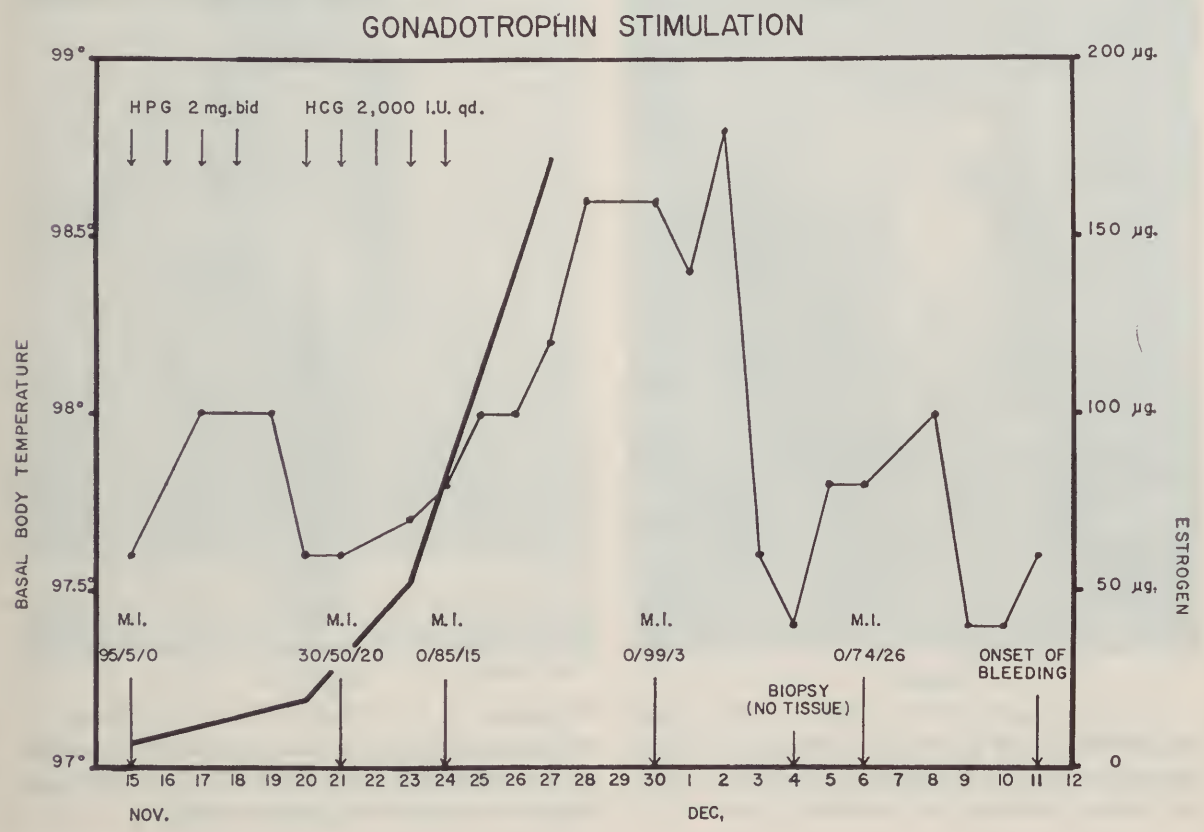
indicated that ovulation had taken place and the measure of the urinary estrogen excretion indicated substantial response. The maturation index furthermore shifted to the right and menstruation occurred after a luteal phase of about 14 days (Fig. 2).

LESIONS OF INTERMEDIATE ORIGIN

A 17 year old patient complained of primary amenorrhea. Her breast development, although never very great, had nevertheless appeared at about 10½ years and axillary hair and pubic hair in rather normal amounts soon thereafter. Her growth and development were otherwise normal. Physical examination revealed a healthy appearing girl 5′ 9″ tall. There was very modest hirsutism over the face, but there was no excess body hair and the axillary and pubic hair was entirely

Figure 2

A chart showing the effect on basal body temperature, estrogen excretion and maturation index of the injection of human pituitary gonadotrophin followed by human chorionic gonadotrophin in the patient shown in Figure 1.



normally developed for a female. The general physical examination was otherwise normal. The breasts, although small, were considered within normal limits. Pelvic examination revealed normal external genitalia without any enlargement of the clitoris. It was necessary to examine internal genitalia by rectal examination. This revealed a normal uterus in good anterior position and no adnexal enlargement.

The urinary 17-ketosteroid excretion was 13.7, 15.0, 15.2 and 23.7 mg/24 hrs. on four independent examinations. An intravenous pyelogram revealed a large calcified mass over the left kidney which was considered to be a calcified adrenal tumor (Fig. 3). This was removed through a transperitoneal incision. Following removal of the tumor, the patient's periods started and were regular. She subsequently married and has had two children.

LESIONS OF GONADAL ORIGIN

A 19 year old girl complained of primary amenorrhea. There was no history of breast development. Hair had appeared under the arms and in the pubic area at the usual time, but had never been very great in amount. There was no excess body hair elsewhere. She was normally intelligent and was doing well in college.

Physical examination revealed a patient who was 5 feet 6 inches tall and weighed 110 pounds (Fig. 4). She had always been thin. There was no breast development, no acne, no hirsutism, but she had scanty pubic and axillary hair. A very careful general physical examination failed to reveal any somatic congenital abnormalities. The external genitalia were normally formed but appeared undeveloped. The vaginal mucosa was quite atrophic. The rectal examination revealed a small infantile uterus and the ovaries were not palpable.



Figure 3

An intravenous pyelogram in a patient with primary amenorrhea. There is a large calcified mass above the left kidney. On exploration this proved to be the virilizing adenoma of the adrenal gland.

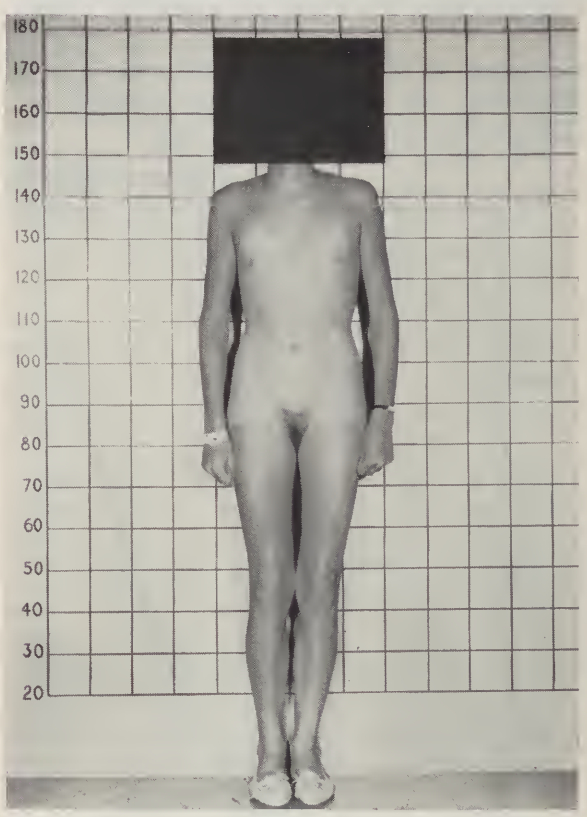


Figure 4

Photograph of a 19 year old girl complaining of primary amenorrhea. The only evidence of secondary sex development is pubic and axillary hair. The final diagnosis proved to be gonadal aplasia.

The vaginal smear had a maturation index of 78-17-5. The urinary gonadotrophin excretion was positive to 52.8 and 103.6 mouse units per 24 hrs. The urinary 17-ketosteroid excretion was 2.7 mg/24 hrs. and the 17-hydroxycorticoid excretion 8.6 mg/24 hrs. A buccal smear was negative.

The diagnosis was considered to be gonadal aplasia without evidence of Turner's stigmata. The patient was treated by cyclic estrogen therapy.

LESIONS OF PERIPHERAL ORIGIN

A 17 year old girl complained of primary amenorrhea. Breast development was noted at about the age of 11 and soon thereafter pubic and axillary hair appeared in normal amounts. The patient was normally intelligent and was doing well in high school. Her growth and development had been otherwise normal although she came from a family of short individuals.



Figure 5

Photograph of a 17 year old patient with primary amenorrhea and with excellent secondary sex development. Diagnosis proved to be congenital absence of the vagina and uterus.

Physical examination revealed a patient who was 5 feet 1 inch tall and weighed 95 pounds (Fig. 5). The general physical examination was entirely negative. Pelvic examination revealed pubic hair normal in amount with female distribution. The clitoris was normal. On separating the labia, the urethral orifice was found to be normal but there was no vaginal orifice (Fig. 6). On rectal examination no internal genitalia could be palpated. The buccal smear was positive—32%.

The diagnosis of congenital absence of the uterus and vagina was made and the patient advised that she could have an artificial vagina made when she was contemplating marriage.



Figure 6

Photograph of the external genitalia of the patient shown in Figure 5.

SUMMARY

1. The majority of patients with primary amenorrhea have some congenital defect.

2. A careful history and physical examination is indicated in any patient suspected of having primary amenorrhea regardless of her age.

3. If by the age of 14 the menstrual periods have not appeared and the other signs of puberty are also absent (breast development, axillary and pubic hair, growth spurt, etc.), a complete laboratory investigation is urgently indicated.

4. If by the age of 18 menstruation has not appeared, a complete laboratory investigation is indicated whether or not other signs of puberty have appeared.

5. A classification of primary amenorrhea is given with examples from each of the major subdivisions.

GUILLIAN—BARRÉ DISEASE COMPLICATING PREGNANCY

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A neurologic symptom complex described in 1856[7] by Landry and subsequently amplified by Guillian and Barré[4] in 1916, is a disorder chiefly confined to the peripheral nervous system. Recent consideration,[8] however, reveals that Landry's paralysis is a descriptive term applied to any ascending paralysis while the Guillian—Barré syndrome is a specific disease. This polyradiculoencephalomenopathy is characterized by an ascending paralysis that begins in the extremities and progresses to involve the facial muscles. Albuminocytologic dissociation of the spinal fluid and accentuation of motor weakness rather than sensory disturbances are integral facets of the disease process. While it may occur at any age it has a propensity for those in the 20 to 50 year group. It is found infrequently associated with pregnancy, and because few instances appear in the literature,[1, 6, 10, 11, 12] the report of an additional case would be warranted.

Since the first description of the disease, neurologists have debated the prerequisites for diagnosis. The questions of specific clinical findings, laboratory data and prognosis are factors that have received attention.[2, 3] Present concepts state that it is a specific entity, its origin being unknown.[5] Large numbers occur without demonstrable cause; however, many are found to follow or be associated with non-specific viral or bacterial infections. Some follow allergic disorders, inoculation with vaccines, collagen diseases or metabolic abnormalities such as pregnancy and diabetes.[8] The need for exact diagnostic criteria was advanced by Osler and Sidell.[9] They presented several valuable yardsticks, the most important of which are (1) the disease begins 1 to 3 weeks after an infection; (2) all sexes and ages are involved; (3) dysethesia of hands and feet precede paralysis; (4) rapid symmetrical loss of power; (5) objective sensory loss is minimal; (6) bladder disturbance is rare; (7) tendon reflexes are lost or diminished; (8) cranial nerves, usually the seventh, become involved; (9) the cerebrospinal fluid shows a rise in protein and a marked increase in cells; (10) complete recovery without residual paralysis occurs within six weeks.

The disease affects the spinal nerves in the region of the fusion of the anterior and posterior roots with proximal and distal extension of the process. However, rather than a mere inflammation of nerves and roots, the syndrome can be viewed as a manifestation of the entire nervous system to injury.[8] Elevation of spinal fluid protein, thought to be frequent, is but an incidental finding according to Guillian.

Case Report

Mrs. L. B., a 34 year old white woman entered the hospital on March 15, 1966 because of weakness of the entire body and inability to close her eyes. One week prior to admittance she had a severe upper respiratory tract infection with fever and malaise. Although she seemed to improve, she continued to complain of numbness and tingling of the fingers, toes and buttocks. Soon the weakness of both lower extremities became so pronounced that she had difficulty in walking. The symptoms gradually progressed so that they included the entire body, and she was forced to remain in bed. In addition, there was dimness of vision and inability to open or close her eyes. Dyspnea or dysphasia was not present. Although urinary incontinence developed, she was able to control bowel movement. There was no fever, chills, nausea, vomiting, headache or stiffness of the neck. The speech became slurred and saliva dripped from the sides of her mouth. She was para 66006 whose menstrual cycles had always been regular. The last regular period occurred on July 30, 1965. She was obviously pregnant (33 weeks) and the estimated date of confinement was May 6, 1966. The family, past and systemic histories were non-contributory. At physical examination the patient was a well developed, thin white woman, obviously pregnant; emotionally disturbed because of her illness. The secondary sex characteristics were well developed. The most notable finding was that she was unable to change her facial expression or close her eyes. There was obvious lacrimation and salivation. The blood pressure was 130 systolic and 90 diastolic; the pulse was 92; rectal temperature 99°F. Examination of the soma was not remarkable. She was 30-32 weeks pregnant, with the fetus in a cephalic presentation. The fetal heart tones were of good quality and located in the left lower quadrant of the abdomen. Of prime interest was the neurologic examination. There was bilateral, peripheral, seventh nerve paralysis; there was no nystagmus. The tongue moved loosely and a good pharyngeal reflex was present. The neck was not stiff or limited in motion. Deep tendon reflexes were exaggerated but equal. Babinski and Hoffman reflexes were absent. The position sense was intact as was pin-prick sensation. Muscle weakness of mastication and the hand was slight. She was unable to ambulate. Laboratory data revealed a 20 mg. per cent spinal fluid protein (upon admittance) with one leucocyte per high powered field. One week later the spinal fluid protein had risen to 36 mg. per cent, and no cells were found. Further tests which included hemophile, hematocrit, erythrocyte count, blood culture, serologic tests for syphilis, agglutination tests and urine examination gave no additional information. Supportive and symptomatic treatments were given and gradual improvement was noticed. The muscular weakness disappeared and within three weeks from the onset she was again ambulatory. On April 2, 1966 she was discharged from the hospital. When the patient was approximately 37 weeks pregnant she fell into labor spontaneously. Within two hours she was delivered of a live male child that weighed 5 pounds 9 ounces. The post partum course was uneventful. At the 6 week period her general condition was excellent. Despite continuous physiotherapy, slight weakness of the facial muscles continued for 3 months. At the four month period she was entirely well, with no residual paralysis.

DISCUSSION

Pregnancy has often been associated with vague tingling sensations of the hands, feet, upper and lower extremities and buttocks. While the exact cause of these complaints is difficult to determine, their etiology has been ascribed to pressure of the heavy uterus or fetus upon nerves, postural deviations, anemia, circulatory disturbances and the ingestion of medication. Although toxemia of pregnancy must be considered, some conditions such as aphasia, hemoplegia, convulsions and syncopal episodes should also receive attention from another standpoint. While serious neurologic disorders are not often seen in conjunction with pregnancy, investigative procedures are imperative so that a pathologic neurologic entity is not overlooked. One of the unusual ones is Guillian—Barré disease. Its appearance is cause for concern until a diagnosis is established because such complications as bulbar paralysis or cardio-respiratory involvement offer problems of fetal oxygenation—as well as the obvious ones to the mother. Since the etiology of Guillian—Barré disease is unknown, treatment is directed to symptomatic relief and general supportive measures.

(*Continued on page* 56)

SNEAKY SPIDER'S BITE IS SERIOUS

More Americans are having unpleasant experiences with the "brown recluse," a sneaky spider with a bite probably more toxic than that of the "black widow." Now seen in a dozen midwestern and southern states, the shy brown spider (Loxosceles reclusa) seems to be expanding its territory. Tourists probably will contribute to its spread this summer when they carry it home in their personal belongings.

The brown recluse tries to stay away from humans, but it hides in places where it can hardly avoid them—shoes, blankets, rolled-up newspapers, the dark corners of man-made structures, etc. The result often is a bite that the person is not aware he is getting, but which becomes painful and swollen later. A few deaths have been attributed to brown spider bites.

The brown spider's venom is now being studied for possible medical uses. Investigators at Little Rock (Ark) Veterans Administration Hospital and the University of Arkansas Medical Center have developed techniques for "milking" the spiders of their venom by giving them mild electric shocks.

"Our data indicate a bilogical poison much more potent than known snake venoms, and probably more toxic than venom from the black widow spider," said Paul N. Morgan, PhD, a research micro-biologist at Little Rock VA Hospital.

The Brown Recluse is being seen in an increasing number of states, say the Arkansas investigators, and physicians should consider its bite a a cause when examining certain types of lesions. The spider has been reported in southern Colorado, Kansas, Missouri, southern Illinois, North and South Carolina, Georgia, Alabama, Mississippi, Arkansas, Louisiana, Texas, and Oklahoma.

It was only ten years ago that University of Missouri investigators discovered the poisonous qualities of the brown recluse. Until then, the black widow (Latrodectus mactans) was believed to be the only North American spider capable of inflicting serious injury on man. So little is known about spider venom that it's impossible to estimate what might constitute a regularly fatal dose, Dr. Morgan said. It is known that the female brown spider ejects approximately twice as much venom as the male. (Only the female black widow is venomous.)

Preliminary studies indicate that the venom can be chemically separated into toxic and nontoxic components. It may be possible to use the nontoxic fractions as a poison antidote, Dr. Morgan said.

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HYPERCALCEMIA WITH SPECIAL REFERENCE TO HYPERPARATHYROIDISM

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The diagnosis of hypercalcemic states requires a knowledge of the symptoms produced by hypercalcemia and an accurate laboratory whose calcium values are reproducible. This latter point is important since an increase of as little as 0.1 mg. above the laboratory's established upper limit of normal is an indication for detailed study of the patient.

The symptoms of hypercalcemia fall into three main groups: gastrointestinal, neuromuscular and urinary.

The gastrointestinal symptoms may include anorexia, nausea, vomiting, hematemesis, constipation and indigestion. Neuromuscular symptoms include headache, irritability, apathy, ataxia, odd behavior, insomnia and coma. Urinary tract symptoms are polyuria, thirst, renal colic and hematuria (these last two symptoms being related to the passage of urinary tract stones). The most important physical finding in hypercalcemia is band keratopathy: a greyish white deposit on the lateral borders of the paralimbic areas of the cornea.

Hypercalcemia is not a disease, but a sign of disease and the states in which it is most commonly found in adult life are as follows: Boeck's Sarcoid, Vitamin D intoxication; milk-alkali syndrome; multiple myeloma; carcinoma metastatic to bone; carcinoma without bone metastases; and hyperparathyroidism. Addison's disease, hyperthyroidism and immobilization are additional, not very common, causes of hypercalcemia.

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Boeck's sarcoid may present as an asymptomatic disease. In such cases, the chest x-ray may show bilateral hilar adenopathy or the appearance of miliary tuberculosis. However, the disease may be more fulminating and present as the uveoparotid syndrome. Arthritis, renal stone, or unexplained pancreatitis are other modes of appearance of sarcoidosis. The hypercalcemic patient with Boeck's Sarcoid is practically always symptomatic. The diagnosis can be suspected from the clinical picture and confirmed by the Kveim test, node biopsy, response of the hypercalcemia to cortisone, and the serum protein electrophoretic pattern.

Vitamin D intoxication in adults in the United States is usually the result of treatment of arthritis with large doses of Vitamin D or food fadism. The history is frequently diagnostic and the response to removal of Vitamin D from the patient's program will settle this problem. The hypercalcemia in these patients usually responds well to administration of cortisone.

The milk-alkali syndrome is more complicated. These patients have a history of peptic ulcer treated with absorbable alkali and large doses of milk. Most patients with ulcer disease are no longer treated with absorbable alkalis. However, any cause for alkalosis associated with ingestion

of large amounts of milk may be causative of the same syndrome. Abstention from milk and absorbable alkali will cure this syndrome, but some of these patients actually have hyperparathyroidism and eventually require operation for cure.

Multiple myeloma is characteristically a disease of middle or late life characterized by anemia, bone pain, pathologic fractures, azotemia, proteinuria, and hypercalcemia. The diagnosis is easily confirmed by the characteristic bone marrow picture, electrophoresis of serum and urine, presence of Bence-Jones protein, and x-rays of the skeleton. In this disease there are numerous punched-out areas in the skull, pelvis, ribs and long bones. The absence of reaction around these punched-out areas is typical. Sometimes, however, the bones show only coarsening of the trabecular pattern and loss of density, a picture which is too non-specific to aid in diagnosis.

The patient with carcinoma metastatic to bone is not usually a diagnostic problem, inasmuch as, the carcinoma is usually evident or readily detectable. Such lesions may superficially resemble the bone lesions of multiple myeloma but usually present reaction around the areas of metastasis and often completely destroy portions of bone rather than creating punched-out defects.

One of the most difficult problems centers around the hypercalcemic patient who has carcinoma without bone metastases. These patients are in most instances secreting a parathormone-like substance which produced a syndrome identical with primary hyperparathyroidism. The underlying carcinoma is most frequently bronchogenic carcinoma, but may be renal, pancreatic, ovarian, or uterine.[1] The unpleasant part about this group of diseases is that the carcinoma may be occult and detectable for a long time despite the production of the hypercalcemic syndrome. This situation will be most commonly confused with true hyperparathyroidism and should be suspected when the patient in question is a middle-aged male smoker, inasmuch as, most of the patients with primary hyperparathyroidism are females.

At this point, we should consider the patient with primary hyperparathyroidism. These patients do not have a typical mode of presentation through any of the symptoms previously noted for hypercalcemia may be found. It should be noted, however, that 70% of patients diagnosed in the United States as having hyperparathyroidism, have urinary tract complaints. In addition, one should screen carefully all patients with peptic ulcer and pancreatitis since the patient with primary hyperparathyroidism has an increased incidence of these diseases.[2-3] Band keratopathy and a nodule in the neck are important physical findings if present, but are lacking more often than not.

When the serum calcium is obtained, simultaneously the serum phosphorus, serum protein, alkaline phosphatase and *BUN* are measured. If the serum calcium is elevated all measurements are repeated twice. The patient is then placed on a diet containing 150 mg. calcium. After three days of this diet, a 24 hour urine calcium is obtained. In most instances, the hyperparathyroid excretes 200 mg. or more of calcium on this diet. At this time a 350 mg. phosphorus diet (phosphorus deprivation test) is instituted for three days and serum calcium, phosphorus and protein measured daily. In the hyperparathyroid, this test usually accentuates the electrolyte abnormalities so that the calcium becomes definitely elevated and the phosphorus definitely lowered by the end of the test.

At this stage we usually determine the tubular reabsorption of phosphorus *(TRP)*. We are aware that the test is mis-named, in that active secretion of phosphorus occurs in the renal tubule so that the phosphorus appearing in the urine is the result of glomerular filtration of phosphorus minus the reabsorbed phosphorus plus the secreted phosphorus. We are also aware that creatinine clearance is not a good measure of glomerular filtration in the face of changing urine flows. The *TRP* is a poor test in the patient with renal damage since glomerular filtration rates below 50 ml/min. are associated with low *TRP's* irrespective of the parathyroid status. Despite these limitations, the *TRP* is useful. In our hands this involves two successive twenty minute clearances of phosphorus and creatinine (usually at 8:00 am). The normal value is 87 ± 5. In the hyperparathyroid patient, this figure is decreased.

If the serum calcium is less than 12 mg. we next test the autonomy of the parathyroid glands by evaluating the effect of a calcium load on the *TRP*. It is agreed that the secretion of parathormone is normally inhibited by hypercalcemia and stimulated by hypocalcemia. Normally then, the effect of hypercalcemia would be to shut off

parathormone secretion. However, if parathormone is being secreted by an adenoma, an autonomous structure, as it is in 90% of cases of hyperparathyroidism, increasing hypercalcemia would fail to halt secretion of parathormone. In this test, the patient's tubular reabsorption of phosphorus is measured on one morning, then that evening from 9:00 p.m. until 12:00 midnight, an infusion of 15 mg. of calcium/kg. body weight is given, and the next morning the tubular reabsorption of phosphorus is measured again. If there is no change, we assume the underlying lesion is an adenoma, and this has proved to be the case in our hands.

Cortisone suppression tests are most useful in cases of Boeck's sarcoid or hypervitaminosis D. Cortisone rarely suppresses hypercalcemia in hyperparathyroidism and only irregularly in multiple myeloma and metastatic cancer. It is contraindicated in the milk-alkali syndrome. Cortisone is administered for four days in a dose of 300 mg./day, and its effect on the serum calcium noted. Despite its frequent failure to aid in diagnosis, we usually run this test in the suspected hyperparathyroid patient unless ulcer disease is known or suspected to be present.

The administration of parathormone to a patient already secreting parathormone in large amounts should produce no significant change. This is the basis for the test designed by Kenneth Becker, MD. In this test, one measures the effect of an infusion of parathormone on the tubular reabsorption of phosphorus. As originally described by Becker,[4] the twelve hour tubular reabsorption of phosphorus was measured and compared with a twelve hour tubular reabsorption of phosphorus obtained during a twelve hour infusion of parathormone. This test has been modified by Gershberg[5] to measure the one hour response of tubular reabsorption of phosphorus after the I. V. injection of 200 mg. of parathyroid extract. Normal patients decrease their *TRP* 14% by this procedure; most hyperparathyroid patients do not.

Dr. Becker states that in patients with tumors causing hypercalcemia without osseous metastases administration of parathyroid extract fails to influence the *TRP*, suggesting that these tumors are secreting a parathormone-like substance.[6]

In recent months, there has been increasing interest in the role of glucagon in calcium metabolism. In pancreatitis, it is possible that in at least some cases the hypocalcemia is related to release of glucagon.[7] In measuring the response of a variety of diseases to the hypocalcemic effect of glucagon, it is reported that patients with primary hyperparathyroidism are unusually sensitive to glucagon.[8] This may become the basis of an additional test for hyperparathyroidism in the future.

As radio-calcium and radiostrontium turnover studies become more available, they will add an additional parameter, since bone turnover in hyperparathyroidism is invariably increased.

Likewise, when immuno-assay of parathormone is perfected further, it will be a marvelous tool for clarification of parathyroid disease. However, parathormone is a relatively poor antigen and a reproducible simple assay is not yet available.[9]

The x-ray is extremely helpful in all patients suspected of hyperparathyroidism. Most of the changes are not pathognomonic, but taken in a group they are extremely useful. These patients may show coarsening of trabecular pattern and generalized increased radiolucency of bone, but more specific are sub-periosteal resorption of bone, disappearance of the lamina dura, increased radiolucency of the distal ends of the clavicles, bone cysts, ground glass appearance of the skull and loss of definition of the inner table of the skull.

Nephrocalcinosis and renal stones are readily demonstrated by x-ray. The oesophagram has revealed an adenoma in one instance in my experience.

It should be emphasized that the entire routine is not followed in every case. The x-ray studies, though discussed last, are done quite early in the study of patients with suspected hyperparathyroidism and may settle the diagnosis before the other listed studies are done.

The diagnosis of primary hyperparathyroidism is time consuming and often difficult. The reward lies in the opportunity to cure a disabling and sometimes lethal disease.

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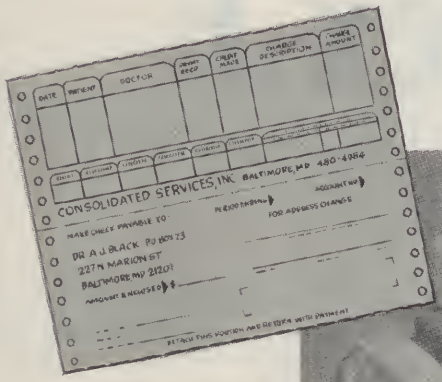
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Tetrex-F (tetracycline phosphate complex-nystatin) is especially useful in patients most susceptible to fungal overgrowth during tetracycline therapy: (1) the elderly or debilitated, (2) young children, (3) the diabetic, (4) those on long-term tetracycline therapy, (5) those on steroid therapy, (6) those who have had moniliasis before, and (7) pregnant patients with a history of monilial vaginitis.

When you start with economical Tetrex-F (tetracycline phosphate complex-nystatin), you can complete the full course of broad-spectrum therapy with less chance of losing control elsewhere. A good start for a healthy finish.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

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Alcoholism SECTION

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

Senator Tydings Supports Comprehensive Alcoholism Programs

In Maryland, during the 18-month period extending from Jan. 1, 1964 through July 1, 1965, 12,785 individuals were convicted of public intoxication, and 3,533 of these people had more than one conviction for this so-called offense within a 12-month period during that time. Think of the incredible waste of our police force, and the degrading effect upon the judges who must daily pretend to dispense justice to these unfortunate individuals. I am informed that the Baltimore Sun papers have reported some 27 deaths of persons arrested for drunkenness, while waiting for a court hearing, in the past five years alone. It is incredible that a civilized society could perpetuate as barbaric a custom as this one.

What of the rehabilitative treatment available for derelict inebriates in Maryland? A recent report of the Department of Mental Hygiene tells the whole story:

"The State hospitals have no treatment program for habitual drunkenness offenders, although the State Department of Mental Health has proposed, and requested financing for, a rehabilitation facility for long-term re-education of these individuals." *

(The above statement is excerpted from a paper presented by Maryland's junior U. S. Senator, Joseph D. Tydings, at the annual meeting of the Washington Council on Alcoholism May 23, 1967. The whole address was published in the Congressional Record for the same day.)

The new facilities which are available for intensive treatment are overcrowded and understaffed. Although State department mental health officials are aware of the need to develop new facilities, no funds have been appropriated for this purpose. Thus, it is clear that the State of Maryland, and indeed the rest of the country, has hardly begun to face up to the problems in this area.

I was startled to read in a newspaper several months ago that judges in Rockville, Maryland, had issued a report stating that although the "Easter" decision is not applicable to them, the problem of the chronic inebriate offender should be studied and dealt with because, at some time in the near future, the Maryland courts might also adopt this approach. These judges either did not understand, or were totally unaware of, or simply were refusing to apply, the "Joe Driver" decision handed down by the Fourth Circuit Court of Appeals in January, 1966. In that case, the court held that the eighth amendment to the United States Constitution prohibits conviction of a chronic alcoholic for public intoxication.

I cannot overemphasize the fact that the Driver decision, which adopts the identical rule as the Easter decision, is binding upon every judge in every court in the State of Maryland today. The Maryland judiciary is therefore obligated, just

like the District of Columbia judiciary, to inquire into the possible applicability of the defense of alcoholism for every inebriate who appears before the courts. Thus, my own State is facing the same problem that the District of Columbia has been facing for the past year.

The U.S. Crime Commission, like the D.C. Crime Commission, has pointed the way out of this archaic use of the criminal law to punish inebriates.

Our communities in Maryland and throughout the country undoubtedly have not had sufficient time to react to it, and to begin to make new plans. They must be given the incentive to do so.

I have co-sponsored with 35 other Senators the Javits-Moss bill, S. 1508, which would provide Federal incentives to assist the States in meeting their responsibilities in this area. As the U.S. Crime Commission has recognized, the Federal Government has a large stake in assisting States in removing the problem of public intoxication from the criminal system and handling it through public health, welfare and rehabilitation procedures.

The bill that has been introduced can, I am certain, be strengthened. I would like to suggest four points which I believe should appear in any final legislation.

First, S. 1508 presently contemplates that detoxification facilities would be provided through law enforcement agencies. It is now evident that the entire problem of public intoxication should be handled outside the sphere of law enforcement, and S. 1508 should therefore be revised in that respect.

Second, it is clear that the problem of public intoxication can be removed from the criminal system only through the coordinated efforts of all interested public and private agencies and institutions. The requirement for a broad community-wide plan for the control of intoxication and alcoholism, to be coordinated with other comprehensive health planning already provided for in Federal legislation, should be included in S. 1508.

Third, it is apparent that the problem of alcoholism has been sadly neglected by the Federal Government for the last twenty years during which significant health and welfare legislation has been enacted covering other serious problems. S. 1508 should include a congressional mandate that all other Federal legislation in the field of health, welfare, and rehabilitation must be utilized in the fight against alcoholism, and the specific statutes pertinent to this problem should be listed.

Fourth, as I have already noted, it is shocking to learn that the problem of alcoholism among Federal employees is handled by firing them, not rehabilitating them. S. 1508 should contain a specific statement of Federal policy abolishing this inhumane practice.

Finally, the Federal efforts in the area of alcoholism are presently split up among a number of departments and agencies. Provision should be made in S. 1508 for an intra-governmental committee that will coordinate these efforts, reduce duplication of work and insure a more efficient and effective treatment program.

The problems that I have discussed today are just really beginning to appear around the country. Courts in other States are beginning to study these problems, and soon will force local communities throughout the country to change their ways if these changes do not come voluntarily. The Federal Government must make certain that our local communities have the resources to meet these problems, and to resolve them, before they overwhelm us.

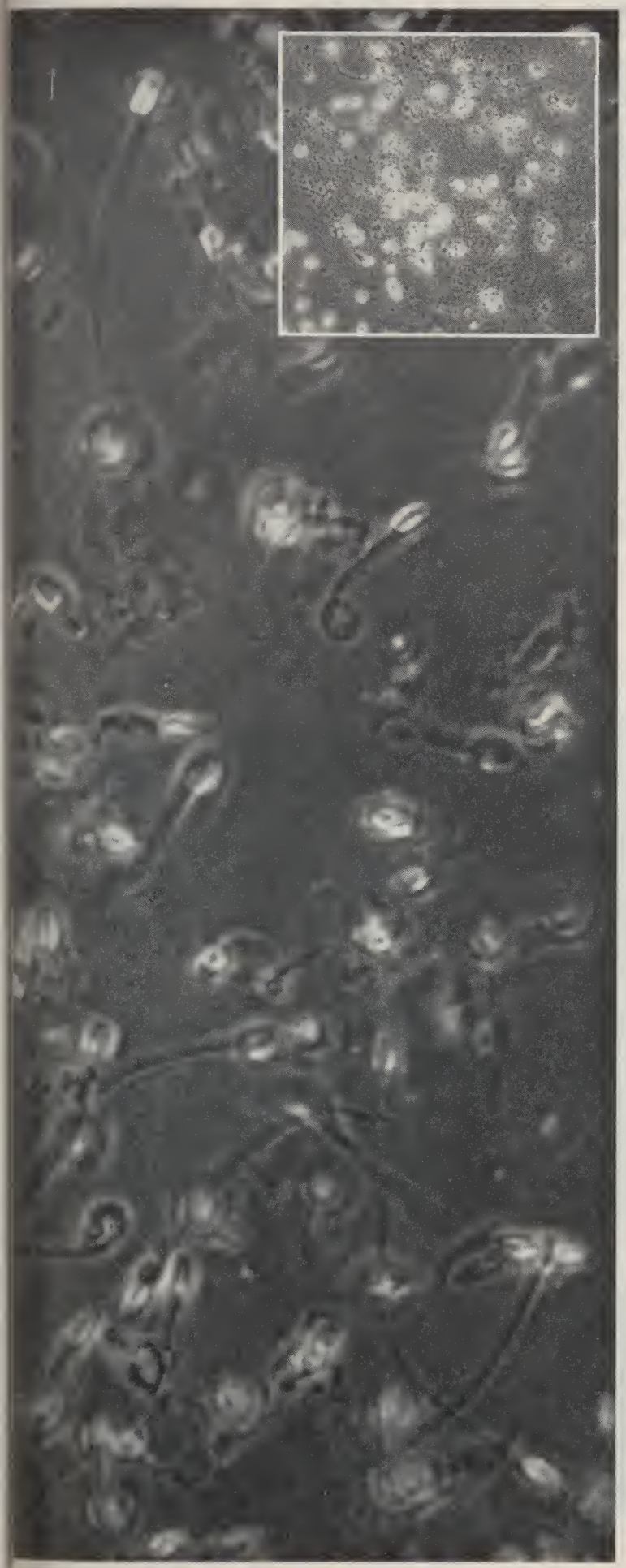
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* Planning money for a 200-bed facility for this purpose was granted the Department of Mental Hygiene in its Fiscal '67 budget. Construction money is being included in the '69 budget request.

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New view of an oral contraceptive at work

Although suppression of ovulation remains the primary mode of action of oral contraceptives, newer knowledge indicates that products like Norinyl-1—a combination of both low-dosage progestogen and estrogen for the full treatment cycle—may provide multiple action that helps explain their unexcelled record of contraceptive effectiveness. This report explores the possible secondary protective mechanisms offered by combined hormonal administration.

Accumulating evidence has indicated that sparse, highly viscous cervical mucus has a possible adverse effect on the motility and survival of spermatozoa.

The estrogen-opposing progestational ingredient of Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.) changes the usual mid-cycle picture of a thin, watery cervical mucus. The result—a built-in barrier that appears to inhibit sperm from reaching the ovum should one be released. The inset in the adjoining photograph shows immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

See last page for contraindications, precautions, side effects and dosage.

How the estrogen-opposing action of Norinyl-1 creates cervical mucus that may be hostile to sperm penetration

Normally, estrogen activity during the fertile midcycle stimulates the production of a profuse and watery cervical mucus that permits maximum sperm motility and promotes penetration.

But what happens when Norinyl-1 is administered? Its potent progestogen, norethindrone, opposes estrogen stimulation of cervical mucus. Consequently, the amount of mucus decreases and its viscosity increases. This results in a sparse but thick mucus barrier that appears to diminish the vitality of the sperm and to impair its powers of penetration.

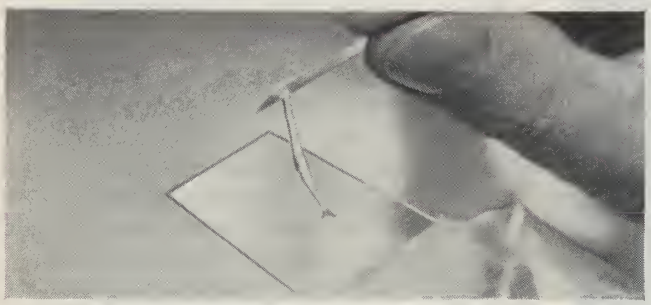
The role of viscous cervical mucus as a secondary action of Norinyl-1

In a report on 89 patients taking this medication,* cervical mucus obtained from cycle day 5 to cycle day 29 appeared scant and thick and exhibited little or no Spinnbarkeit.

In the opinion of this investigator, the effect on cervical mucus may be sufficient to prevent conception.

*Cohen, M. R.: Symposium: Mechanisms of Action of Low Dosage Oral Contraceptive, Yale University Medical Center, New Haven, Conn., April 6, 1967.

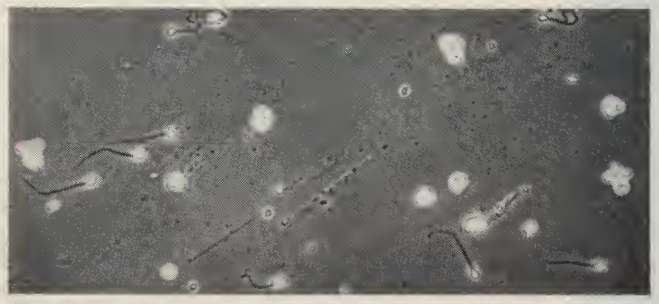
Normal cervical mucus at midcycle in untreated patient is known to permit sperm motility... promote sperm penetration.



Cervical mucus is thin and watery with a stretchability (Spinnbarkeit) of 15 to 20 cm.

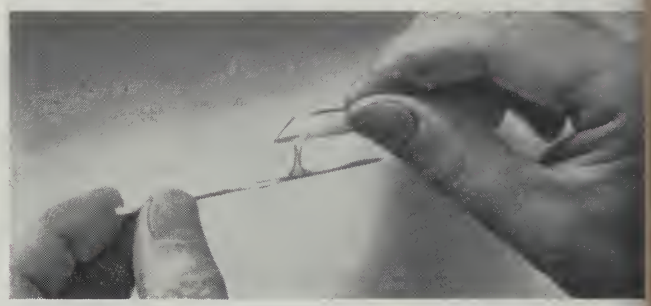


Thin, watery mucus crystallizes into this well-defined, fernlike pattern within a minute.

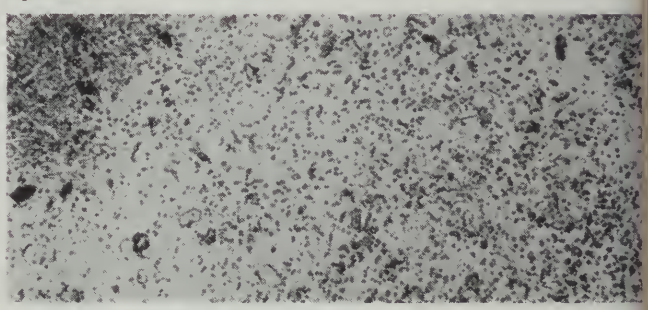


Spermatozoa appear healthy, are active and freemoving.

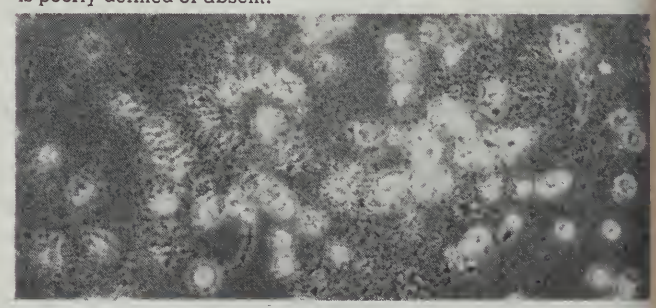
Viscous cervical mucus at midcycle produced by Norinyl-1 appears to impair sperm vitality... inhibit penetration.



Cervical mucus is scanty, thick and viscous. Spinnbarkeit is 1 cm. or less.



In thick, viscous cervical mucus the fern pattern is poorly defined or absent.



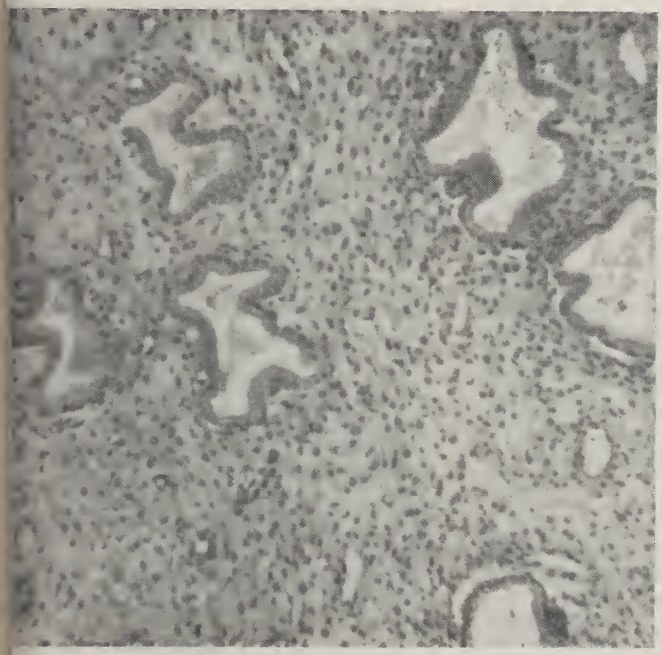
Immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

How Norinyl-1 alters normal endometrial responses—another possible protective mechanism

Let us suppose that an ovum is released—as occurs in an occasional, rare case—and somehow a sperm succeeds in penetrating the cervical mucus barrier. Should this come about, one additional action of Norinyl-1 may protect the patient from unwanted pregnancy. The theory is that progestogen intake makes endometrial tissue unreceptive to implantation.

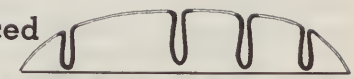
Endometrium of untreated patient

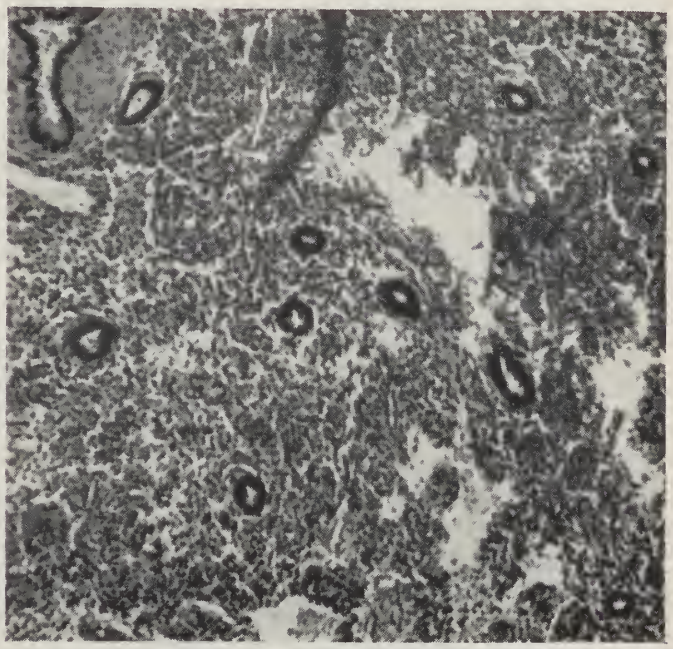




Normally, the endometrium progresses through a proliferative phase stimulated by estrogen and a secretory phase stimulated by progesterone. During the secretory phase the endometrium is receptive to the fertilized ovum.

Endometrium produced by Norinyl-1





When Norinyl-1 is administered its progestogen component—norethindrone—accelerates the secretory phase and suppresses glandular and vascular development.

See last page for contraindications, precautions, side effects and dosage.

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effective fertility control on half the previous dosage

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lower cost

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(norethindrone 1mg. c̄ mestranol 0.05mg.) **tablets**

Reduction of oral contraceptive dosage to lowest effective levels has become a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now available in a new strength in which *both* norethindrone and mestranol are reduced 50 percent. Studies show that Norinyl-1 achieves fertility control with only 1.05 mg. of combined progestogen and estrogen per tablet.

Norethindrone was first reported for use as a progestational agent in human beings in 1955. Norethindrone 2 mg. with mestranol 0.1 mg., as an oral contraceptive, is currently in use by over 2,000,000 women. Clinical experience now establishes that Norinyl-1 also amply meets the criteria of reliability and safety.*

*Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965.

PRESCRIBING INFORMATION

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of Norinyl-1 in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with Norinyl-1. Therefore, if such tests are abnormal in a patient taking Norinyl-1, it is recommended that they be repeated after the drug has been withdrawn for 2 months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibroids may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac, or renal dysfunction, require careful observation. 5. Although a cause and effect relationship has not been established, Norinyl-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, as in all cases of irregular bleeding *per vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged Norinyl-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Norinyl-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. A cause and effect relationship has not been demonstrated. 11. Because of the effects of estrogens on epiphyseal closure, Norinyl-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask the onset of the climacteric. 13. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma, breast changes (tenderness, enlargement and secretion), loss of scalp hair, change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, erythema multiforme, erythema nodosum, hemorrhagic eruption, migraine, rash (allergic), itching, rise in blood pressure in susceptible individuals, mental depression.

The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has not been established: thrombophlebitis, pulmonary embolism, neurooocular lesions.

The following laboratory results may be altered by the use of oral contraceptives: increased bromsulphalein retention and other hepatic function tests, coagulation tests (increase in prothrombin, factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metapyrone test, pregnanediol determination.

Other side effects reported to have occurred in association with use of this drug are dizziness, hirsutism, pains in legs, back, chest and abdomen, dysuria, drowsiness, vaginal discharge, libido increased and decreased, eruptions, hypermenorrhea, hypomenorrhea, increased appetite, G.U. infections, varicose veins, abdominal fullness, acne, headache, nervousness, allergies, blurred vision, pain in eyes, and itching in eyes. *For complete clinical data, see package insert.*

Dosage and Administration: 1. One tablet of Norinyl-1 is administered orally for 20 days beginning on day 5 of the menstrual cycle. (Count day 1 of the cycle as the first day of menstrual bleeding.) Repeat this dosage schedule for each cycle. 2. If no menstrual period occurs after a cycle of treatment (20 tablets) in which patient adhered to the schedule, the patient must be instructed to resume taking the Norinyl-1 tablets 7 days after the previous 20 day course was completed. For example, if the last pill of a previous cycle had been taken on a Sunday, then a new cycle of treatment should begin on the following Sunday. 3. In the postpartum woman, it is recommended that the first cycle of treatment should begin on day 5 of the first menstrual cycle. However, Norinyl-1 should not be administered during lactation.

Availability: Norinyl-1 (norethindrone 1 mg with mestranol 0.05 mg.)—Dispensers of 20 and 60 and bottles of 250 tablets.

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The Maryland Academy of General Practice

The Inevitable Cry

G. OVERTON HIMMELWRIGHT, MD
Past-President, Maryland Academy of General Practice

Go into any church, Beauty Shop or PTA, and what conversation does one hear the most? It is the *cry,* "I can't get a doctor." This *cry* is directed more to the family physician and general practitioner than any other physician. It is now felt in the specialist's office as well. The patient is saying, "I want a doctor that will accept me as a total patient, see me for first contact, and then give me comprehensive and continuing health care."

One only has to go a short time back into history to realize why this *cry* is so great today. In 1931, no less than 84% of U.S. Physicians called themselves General Practitioners, today this number has shrunk to between 35% to 38%. Approximately only 16% to 18% of this year's medical graduates expect to go into general practice. Yes, the General Practice has lost it's image to the fast growing number of specialists; however, the specialist is fast losing his image to the general public as they can't quite understand when they need a *doctor,* a large proportion of the specialists are unable to care for them. For example the following chart will show the breakdown of number and types of physicians in my home county, Allegany: This might be broken down even further as to the physician ratio to population as to specialist, part-time specialist, and the non-specialist, to give you some idea as to why in Allegany County one keeps hearing this continuous *cry.* This is not unique only for Allegany County, it is found in most counties in Maryland as well as all over the U.S. To quote from the Baltimore City Health Department's 1964 statement of Problem and Background data on the Overloading of Outpatient Facilities of hospitals in Baltimore City, "the figures show that in 14 years the number of doctors per 100,000 population in Maryland has presented an about-face in type of practice. In 1949, there were 97 doctors per 100,000 population. Of these, 56 were in general practice and part-time specialization, 41 were in full time specialization. In 1963, there were 87 doctors for 100,000 population figure; but 31 were in general practice and 56 were specialists, which represents a state-wide as well as a national trend."

Of course, we do know that this is not a true comparison. More non-specialists see patients for

TOTAL PHYSICIANS VS. SPECIALTY OR PART SPECIALTY VS. NON-SPECIALTY

Date	Total Physicians Allegany County	Specialty or Part Specialty	Non-Specialty
1940	69	39	30
1966	73	63	10

PHYSICIAN RATIO TO POPULATION IN ALLEGANY COUNTY

Date	Total Population	Specialists and Part-time Specialists	Non-Specialists
1940	86,973	1:2230	1:2899
1966	84,169	1:1336	1:8416

the first contact, and give them comprehensive and continued care. But, by statistics, this is a true figure, just as much as we need 150 physicians born by 1975 to take care of a total population of 100,000 people. Somewhere, and somehow, medical education will have to be geared for the production of physicians who will have first contact with patients, giving them comprehensive and total health care.

With our ever more complex American Society, the increasing demands of the public for more and better medical personnel and facilities, medicine must act now to fill the gap. If not, Government will assume the responsibility for doing so.

It is hoped that organized medicine has "rushed to the scene of the emergency in time to save the patient."

Proposals for educating the physician of the future are detailed in the AMA's *Council on Medical Education.* Reports of (a) *Citizens Commission on Graduate Medical Education*—the *Millis Report;* and (b) the *Ad Hoc Committee on Education for Family Practice* as well as the *Core Content of Family Medicine* prepared by the AAGP *Committee on Requirements for Certification.*

Our own State also has been interested. As a result of the passage of Senate Joint Resolution No. 9, introduced by Senator Harry Hughes in the 1964 session of the Maryland Legislature, a Commission was appointed by former Governor Millard J. Tawes "to study and report on the acute problem resulting from a shortage throughout many parts of Maryland of general practitioners in medicine." This Commission reported its findings and recommendation to the Governor and to the Legislators in the 1965 Session of the General Assembly.

Although the *Ad Hoc Committee* and the *Citizens Commission* necessarily overlap in some areas, many recommendations of the two bodies are consistent and reinforcing.

The *Ad Hoc Committee* was also aware of the patient's *cry,* in that the report states, ". . . the American public needs and wants a large number of well-qualified family physicians to provide comprehensive personal health care. These physicians should be specialists prepared through new types of educational programs to meet the medical care needs of the future. As specialists, they should be entitled to appropriate specialty board certification."

The AAGP's *Core Content of Family Medicine* concludes, as does the Millis Report, that the *family physician* or *primary physician* should be proficient in preventive medicine, as clinical medicine, such as psychiatry, pediatrics, office gynecology and internal medicine. He should also be proficient in rehabilitation, studies of family and community, the use of community resources and allied para medical personnel, practice management, and practice evaluation.

"But more importantly, as stated in Senator Hughes' Resolution and again in the *Governor's Report,* 'capable and well-trained general practitioners in adequate numbers are an essential ingredient in our system of medical care, the importance of their role in American medicine having been decreed by our social system in which the family is basic and in the common concept of preventive medicine in which comprehensiveness is the objective. . .' It is, in short, just plain good medicine to do everything possible to preserve general practice for if general practice dies, it is the public as well as the medical profession who will be the losers.

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the HEART PAGE

A Service of The Heart Association of Maryland

Elijah Saunders, MD—*Editor*

MANAGEMENT IN THE COMPLETED STROKE

B. STANLEY COHEN, MD
Dept. of Rehabilitation Medicine
Sinai Hospital of Baltimore

Proper management of the patient with the *completed* stroke requires early and aggressive measures. The acute medical management includes careful attention to the problems of ventilation, blood pressure and cardiovascular status, feeding and urinary tract drainage. In the unconscious and confused patient, airway maintenance, intravenous feeding, and avoidance of bladder distention with catheterization are often necessary during the early hours. Frequent turning is required to prevent decubiti and respiratory problems.

Concurrent with attention to life threatening problems, planning for long term management should begin. In more than 75% of patients with stroke, the basic process is infarction, rather than hemorrhage, and in most of these, active rehabilitation measures can be instituted within 48 to 72 hours. Proper bed positioning and passive range of motion prevent troublesome and disabling contractures. Pillows, sandbags, towel rolls, and foot boards may be employed. The physical therapist, nurse, family, and the patient himself may perform passive movement of the extremities through full range at least twice each day. Spasticity may develop early and in the absence of such treatment, tightness develops within days. Morbidity incident to handling should be prevented. Prolonged positioning on the involved side may produce peripheral neuropathies, and traction on the paretic arm, in moving the patient, may result in shoulder subluxation or brachial plexus stretch.

Deconditioning should be avoided. Exercises for maintenance of strength on the uninvolved side are begun and the patient is taught to turn himself in bed. Such a simple measure as a knotted rope attached to the foot of the bed enables turning and sitting. As soon as the vital signs are stable, and often by 48 hours, preparation for ambulation should begin. Sitting balance and tolerance are established and the patient is taught to participate in transfer activities. It is not sufficient for nursing personnel to lift the patient from his bed and secure him in a wheelchair. Hip and knee flexion contractures develop even more easily following prolonged sitting than at bed rest. A bedside commode requires less energy expenditure than the use of a bedpan. With sitting and standing, voluntary voiding is usually accomplished. External collection apparatus may be used where needed. Prolonged catheterization is



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usually unnecessary and results in infection and a spastic contracted bladder with low capacity.

The average patient who can lift the heel of the involved lower extremity about three to six inches from the mattress, while lying on his back, is ready to begin standing. He may begin in the parallel bars and progress to walking with walker or cane, or to independent walking. Initially a temporary foot drop support and posterior splint for the knee may be required. The shoulder of a flaccid arm should be supported with a sling, and persistent foot drop requires a short leg brace. Gait training and the use of the brace reduce considerably the energy requirements of ambulation.

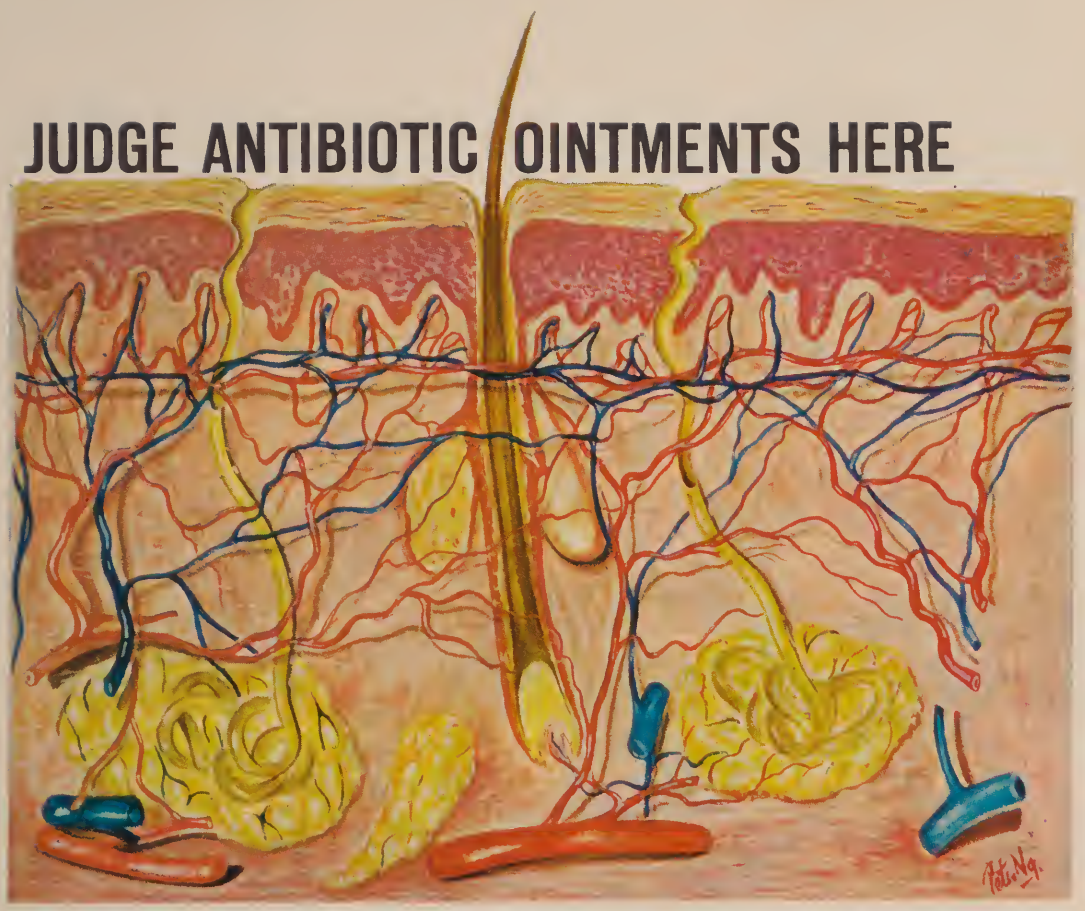
Where prompt return of upper extremity function does not occur, one-handed activities may be taught. Where necessary, change in dominance is accomplished.

When speech is affected, techniques for nonverbal communication may be employed early. As general motor improvement occurs, therapy by a speech clinician will be helpful.

Prognosis for rehabilitation depends, in part, on age, blood pressure, including the presence of hypertensive encephalopathy, visuospacial perceptual problems, and other complicating illness. In the elderly patient, lower extremity function may be expected to approach maximal in several months, and gait training beyond two to three months is usually not productive. Absence of significant upper extremity function, after one or two months, is a poor prognostic sign and usually calls for establishment of limited goals for the upper extremity.

Many of the rehabilitation procedures are best accomplished with the help of trained physical and occupational therapists, but where such personnel are unavailable, acceptable results can be obtained in many patients if the physician is rehabilitation conscious and is willing to assume an active management role. The most favorable outcome may be expected where the goals of treatment are not limited to physical restoration, but are concerned with maximum function of the individual, within his environment, despite residual disability.

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Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

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BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Why these 7 patients wit
moderate to severe anxiet
may respond better to Mellari



1. The agitated patient.
Anxiety—particularly that beyond t
range of minor tranquilizers—f
quently is expressed as gross mo
restlessness, fidgetiness and purpo
less movements, and may erupt i
aggressive behavior. Mellaril is
most a specific for those patie
whose anxiety follows such a patte



2. The psychosomatic patient.

family physician is rarely given diagnostic luxury of a classic, book "anxiety state." Most often ust probe for anxiety masked by nctional disorder—or which exac-tes a somatic problem. Double-d evaluations have demonstrated Mellaril can be a significant ad-t in the treatment of such patients.



3. The patient under ational stress.

aril helps the patient deal with ses of everyday life. Nonhabitu-g, it can be given for extended pe-s of time. It does not "separate" patient from practical problems pressures, does not induce eupho-a fuzziness which can compro-se the ability to cope with reali-es. Rather, it helps the patient move more competently in his daily world by eliminating use-less tension, by allowing him to conserve emotional resources and energies, and to direct them against the problems really worth worrying about.



4. The menopausal patient.

The woman who sees change of life as the end of useful life requires support from both family and family physician. Whether the psychological impact of menopause is directly related to hormonal changes, or merely coincidental, is debatable, but estrogenic therapy is frequently inadequate. Mellaril is a useful aid for these patients and, alone, or in combination with reduced estrogen dosage, will help ease the menopausal misery.



5. The previously hospitalized psychiatric patient.

Such a patient may still require the type of medication he has been accustomed to, but because he is no longer in a controlled setting the acceptable level of adverse reactions must be lower. In such circumstances Mellaril is perhaps the drug of choice.



6. The agitated geriatric.

Tranquilizer therapy in the elderly patient always involves special (or at least accentuated) problems: the possibility of drug-induced ataxia, hypotension or depression, for example, assumes an additional significance. These reactions have rarely been observed in geriatric patients treated with Mellaril.



7. The constantly returning patient.

The anxiety patient who has not responded to a minor tranquilizer is not very likely to benefit from your minor tranquilizer of second choice. A major tranquilizer, such as Mellaril, may be indicated in such patients.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.
Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.
Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.
Before prescribing, see package insert for full product information.

in moderate to severe anxiety, 25 mg. t.i.d.

Mellaril®
(thioridazine)

SANDOZ


Bartholin's gland
Periurethral glands
Cervical glands
Flagyl®.....
brand of
metronidazole
Seminal vesicles
Bladder
Prostate gland

Destroys Trichomonads Wherever They Are

Flagyl seeks out the sites where trichomonads hide. Only a systemic agent can. Flagyl does, selectively and effectively.

Flagyl destroys trichomonads in the inner crypts, glands and cavities of the genitourinary tract in both women and men. Consequently, Flagyl is capable not only of curing trichomoniasis in women but also of preventing reinfection.

Correctly used, with due attention to repeat courses of treatment for resistant, deep-seated invasion and to the presumption of reinfection from male consorts, Flagyl has repeatedly produced up to 100 per cent cure in large series of patients.

When the diagnosis of trichomoniasis is positive, Flagyl is positive.

Dosage and Administration — In *women:* one 250-mg. oral tablet three times daily for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.

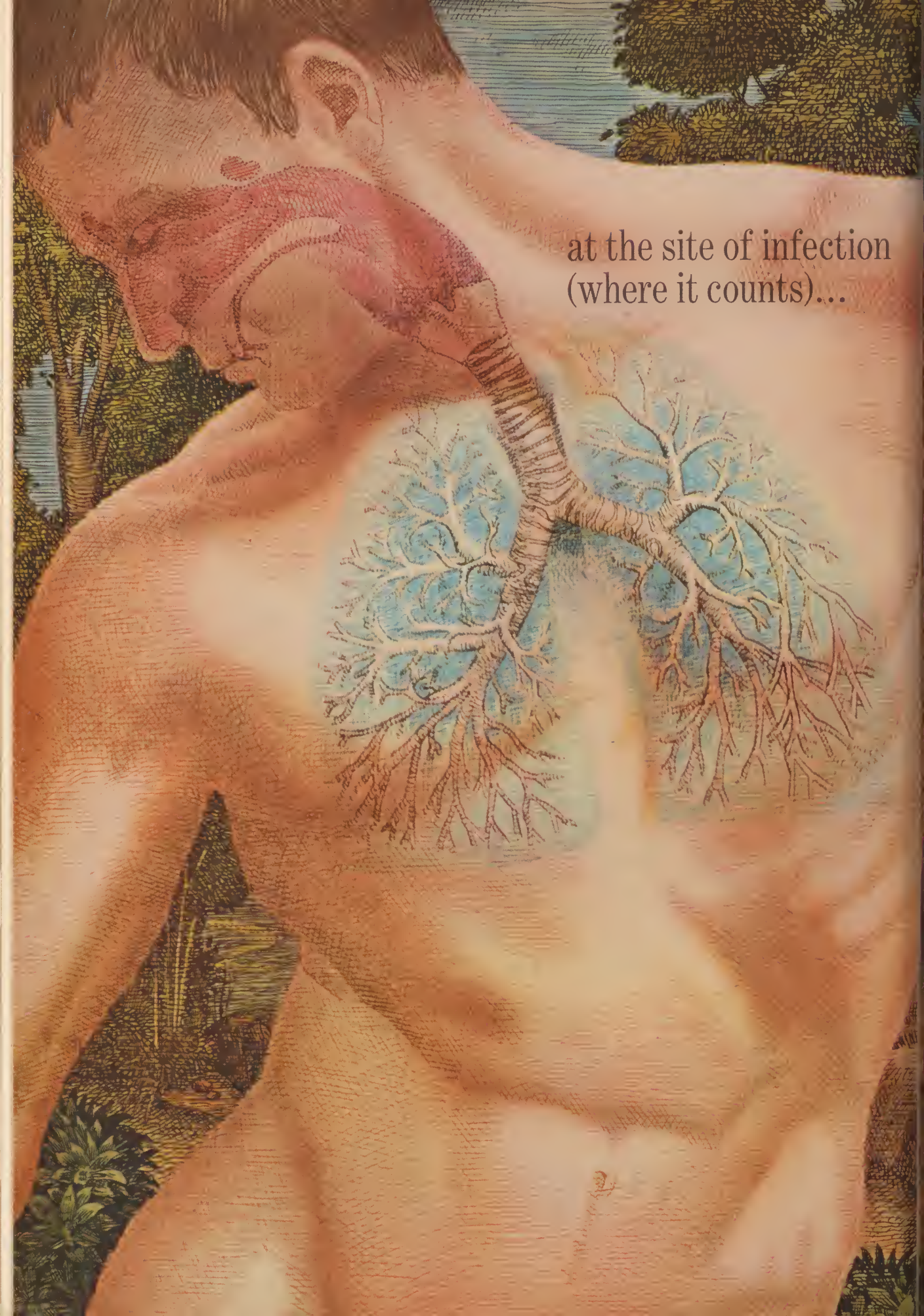
In *men* in whom trichomonads have been demonstrated: one 250-mg. oral tablet twice daily for ten days.

Contraindications — Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precaution—Complete blood cell counts should be made before, during and after therapy, especially if a second course is necessary.

Side Effects—Infrequent and minor side effects include nausea, metallic taste, furry tongue and headache. Other effects, all reported in an incidence of less than 1 per cent, are diarrhea, dizziness, vaginal dryness and burning, dry mouth, rash, urticaria, gastritis, drowsiness, insomnia, pruritus, sore tongue, darkened urine, anorexia, vomiting, epigastric distress, dysuria, depression, vertigo, incoordination, ataxia, abdominal cramping, constipation, stomatitis, numbness of an extremity, joint pains, confusion, irritability, weakness, flushing, cystitis, pelvic pressure, dyspareunia, fever, polyuria, incontinence, decreased libido, nasal congestion, proctitis and pyuria. Elimination of trichomonads may aggravate candidiasis.

SEARLE *Research in the Service of Medicine*


at the site of infection
(where it counts)...

Ilosone® provides more antibacterial activity than any other oral erythromycin

Acid stable, better absorbed... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food[1-3]

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

Now available:
New! Ready-mixed Ilosone Liquid 125! (Contains erythromycin estolate equivalent to 125 mg. erythromycin base per 5-cc. teaspoonful.)

700970

Ilosone® Lilly
Erythromycin Estolate

(See next page for prescribing information.)

Ilosone®/the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have also been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Adverse Reactions: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have developed in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly, usually within forty-eight hours, if the drug is readministered to sensitive patients. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appeared t be definitely related to use of the drug, laboratory findings wer characterized by increased direct-reacting bilirubin, elevate alkaline phosphatase levels, negative or weakly positive cephali flocculation and thymol turbidity tests, elevated serum glutam oxalacetic transaminase levels, peripheral eosinophilia, and no mal cholecystograms.

Individual idiosyncrasy seems evident since jaundice has n been reported in other patients taking prolonged courses of t medication. Patients with chronic infection have been given 1 to 2 Gm. of the drug daily for periods of two to six months, ar patients with rheumatic fever have taken prophylactic doses 0.5 Gm. daily for two years without difficulty. In one group 144 patients who received the drug daily for two years, no jau dice was noted. It was of interest that members of six of the patients' families, who were not taking the drug, had episod of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels we determined in a group of fifty-four adults and children who to 250 mg. of Ilosone daily for an average of sixteen months rheumatic fever prophylaxis. The results were compared wi those of a similar group of forty-four patients who received pe icillin. There were no cases of jaundice in either group. Elevati of SGPT and serum alkaline phosphatase levels during the cour of treatment was observed in one patient treated with Iloso and in two patients treated with penicillin. Seven other patie in the group receiving Ilosone and four others in the penicill group showed elevations in one of the tests at some time duri administration of the drugs.

Very satisfactory therapeutic results, without toxicity, we reported in 102 pediatric patients who received short-term (te day) courses of Ilosone in the treatment of streptococcus inf tions. Results of liver function tests in these patients we comparable to those in a similar control group who had receiv penicillin.

Gastro-intestinal disturbances not associated with hepatic fects are observed in a small proportion of individuals as a res of a local stimulating effect of the medication on the alimenta tract; however, the normal intestinal gram-negative bacter flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with the u of erythromycin, there have been occasional reports of urticar skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orally.

Ilosone Pulvules®, Ilosone Liquid 125, Ilosone, 125, for O Suspension, Ilosone Drops, Ilosone Chewable Tablets.

For infants and for children under twenty-five pounds of bo weight, the usual dosage is 5 mg. per pound every six hours; children twenty-five to fifty pounds, 125 mg. every six hou (Tablets Ilosone Chewable should be chewed or crushed a swallowed with water.)

For adults and for children over fifty pounds, the usual dos of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythromy therapy should be considered.

In the treatment of syphilis, the recommended total dosag 20 to 30 Gm. given in divided doses for a period of ten to fift days. Close follow-up of the patient is necessary since eryth mycin drugs have not had adequate evaluation in all stages syphilis. Examinations of spinal fluid are recommended as p of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four days recommended. In the treatment of gonorrhea, patients witl suspected lesion of syphilis should have a dark-field examinat before receiving antibiotics, and monthly serologic tests sho be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and 250 (equivalent to base), in bottles of 24 and 100.

Ilosone Liquid 125, Oral Suspension, U.S.P., 125 mg. (equival to base) per 5-cc. teaspoonful, in 60-cc. and pint-size packa

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equival to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size packa

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 10-cc.- packages, with dropper calibrated at 25 and 50 mg.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to ba in bottles of 50. [032

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:69, 1. 2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:398, 1. 3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 1960.

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.

Lil

DEPARTMENT OF HEALTH
STATE OF MARYLAND
William J. Peeples, MD, MPH, *Commissioner*

Highlights

Crippled Children Under Title 19

To safeguard the high standards of care which have always characterized the thirty year old State Crippled Children's program, the Health Department recently appointed a subcommittee on Standards of Care of Handicapped Children under the Medical Assistance Program (Title 19), to assist the Department by reviewing and advising on hospital and professional services to handicapped children eligible for Medical Assistance. Proposals developed would be referred for review by the Medical and Chirurgical Faculty which has appointed a group for this purpose.

The subcommittee, chaired by Edward McDonnell, MD, developed the following resolution which was approved by the Council of the Medical and Chirurgical Faculty at its June meeting:

Resolution of the Subcommittee on Standards of Care of Handicapped Children Under the Medical Assistance Program (Title 19)

The Subcommittee on Standards of Care of Handicapped Children recommends to the Medical and Chirurgical Faculty of Maryland and the Medical Assistance Advisory Committee that it reiterates its support of the high standards of care offered through the State Crippled Children's Program, which stands ready to accept the handicapped children particularly where special facilities are needed and are available for treatment also reiterates the concept that the Crippled Children's Program continue to maintain contact with the referring family physician and that encouragement be given to him for his participation in the follow-up and after-care of such patients. The Subcommittee also wishes to have both the Medical and Chirurgical Faculty and Medical Assistance Advisory Committee go on record as endorsing the continuance of the high standards that have been adopted and used in the operation of the State Crippled Children's Program.

The resolution will be presented to the Medical Assistance Advisory Committee for its recommendation to the State Board of Health and Mental Hygiene.

Measles Surveillance Program Instituted

The campaign to end measles during May 1967 resulted in the vaccination of 64,340 children. The next step is to institute a measles surveillance program. This is essential to pinpoint pockets of unprotected children and permit immediate measures to control localized outbreaks of measles.

Prompt reporting and investigation of measles

cases will facilitate this surveillance and provide a continuing evaluation of the effectiveness of the "end measles" program.

The burden of this reporting will fall largely on the private practicing physician. Physicians are therefore requested to report to the local health department all measles cases, giving name, address, date of onset, and any other pertinent data. The yellow communicable disease report form (card) may be used.

Syphilis in Migrant Workers Part of VD Control Study

Case finding and treatment of syphilis and gonorrhea among migrant workers was recently initiated on the Eastern Shore as part of a three-year Venereal Disease Control Demonstration Project being conducted by the section of Venereal Disease Control of the Division of Communicable Diseases.

Blood samples will be taken from each of the estimated 5,000 workers and screened for syphilis by means of the *RPR* card test. Sero-positive specimens will then be given *VDRL* and possibly fluorescent antibody tests to confirm or rule out presence of the disease. Those requiring treatment will be referred to private physicians or local health departments for care.

The study is expected to yield valuable data regarding the influence of migrant workers on Maryland's venereal disease rate, and be a means of early case finding as well. The services will be coordinated with the migrant health programs of other states.

Mosquito-Borne Encephalitis Surveillance Continues

The Department's Division of Communicable Diseases has requested the cooperation of physicians and hospital laboratories in a surveillance program for the detection of cases of mosquito-borne encephalitis on the Eastern Shore. Surveys show the viruses of Eastern and St. Louis encephalitis are constantly present in birds and mosquitoes.

The Division urges routine collection of blood specimens from suspected cases of encephalitis and aseptic meningitis, and shipment to the Bureau of Laboratories in Baltimore, where they will be examined for antibody titres of four types of encephalitis. Specimens may be tested for Echo and Coxsackie viruses or other serology if requested. Attempts will also be made to isolate the virus.

Paired sera are needed to determine a rise in antibody titre, requiring collection of one specimen during the early febrile stage of the illness, and a second 14 to 21 days after onset. If a spinal tap is done, a spinal fluid specimen should also be collected.

Instructions for collecting and handling specimens may be obtained from local hospitals, from the Division of Communicable Diseases, or from the Central Laboratory.

Montgomery County

Hugh B. McNally, MD formerly obstetrical consultant, Division of Maternal and Child Health, is now employed on a full-time basis by the Montgomery County Health Department to be in charge of a maternity program.

New Legislation Permits Treatment of Minors

Senate Bill 315, recently enacted by the General Assembly, permits physicians to render diagnosis and care to minors for pregnancy or venereal disease, without parental consent. Confidentiality is left to the judgment of the physician, except that he is not permitted to reveal any information to the spouse, parent, custodian, or guardian of the minor regarding any appointment, examination, test, or other medical procedure, if his examination shows the condition is not present.

Rubella Registry to be Undertaken

Possibly as many as 1500 Baltimore children born to mothers who fell victim to rubella in the epidemics of 1963 and 1964 may have suffered serious birth defects, a study by Janet Hardy, MD, of the Johns Hopkins Hospital indicates. Statewide, the figure may double this estimate. Anticipating a severe strain on the state's medical, rehabilitative, and educational facilities when these children reach school age, the Departments of Health and Education plan to enlist the cooperation of Maryland physicians in a massive joint effort to find and identify handicaps, so that plans may be made to meet the problem.

New Nursing Home Reimbursement Procedures Issued

Beginning July 1, nursing homes will be reimbursed for the care of Medical Assistance patients on the basis of audited costs plus a percentage

(up to $12 per day total), providing they have: (1) been licensed by the Health Department as a "skilled nursing home" (certification as an extended care facility is automatic qualification); (2) submitted cost figures for the period Jan 1 to Dec 31, 1966, to the Hospital Cost Analysis Service, Inc.; (3) signed an agreement for the audit; and (4) signed the Nursing Home Compliance Report (civil rights agreement).

Nursing homes which have not complied with these requirements will be reimbursed at the old rate, not to exceed $7 per day. If they have still not complied by Sept 1, reimbursement will continue at the old rate for the entire 1968 fiscal year, whether or not the compliance requirements (a cost statement is filed) are met within the year.

Health Departments to Assist Hospitals in PKU Testing

Legislation enacted by the 1967 General Assembly changed the mechanism for phenylketonuria screening of newborn infants, making hospitals the agency solely responsible for ensuring that a satisfactory test is completed. On the infrequent occasion when technical problems result in an unsatisfactory test, the hospital rarely learns of this until the infant has been discharged home. The Commissioner has requested local health departments to assume responsibility for follow-up testing, upon request from the hospital involved.

Course in Salmonellosis Control Given

A course on the control and epidemiology of salmonellosis was recently conducted in Salisbury for public health and agricultural specialists from Maryland, four other states, Puerto Rico, and the District of Columbia. Jointly sponsored by the Health Department, the National Communicable Disease Center, and Region 3 office of the US Public Health Service, the training program was part of a nationwide effort to reduce the incidence of food poisoning.

Attended by sanitarians, engineers, epidemiologists, veterinarians, supervisors of food hygiene programs, and other related specialists, the course was designed to enable participants to lend advice and support to industries and businesses engaged in the processing of foods subject to contamination with salmonella organisms, such as meat and poultry.

It has been estimated that as many as 2 million

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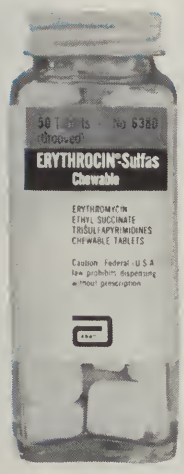
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ERYTHROCIN®-SULFAS Chewable (Erythromycin ethyl succinate-trisulfapyrimidines chewable tablet)

In clinical trials[1,2], this orange-flavored tablet was given to 55 patients, aged four months to 18 years.

Diagnoses (multiple in some cases) represented a cross section of bacterial infections commonly seen in pediatric office practice.

Therapy was given from three to 12 days, with an average of six days.

Of the 55 patients, 30 were reported cured within 72 hours, while 22 showed partial recovery within the same time, and subsequent clinical cure.

A clinical cure rate of 94.5%

ERYTHROCIN®-SULFAS Granules (Erythromycin ethyl succinate-trisulfapyrimidines granules for oral suspension)

87 patients were treated[1,2]—all children, ages four months to 15 years.

The diagnoses were multiple in some cases and were chiefly bacterial infections of the respiratory tract.

Dosage was maintained from three to 10 days; average treatment was five days. All of the ill children accepted the orange-flavored suspension favorably.

53 were clinically cured within 72 hours, while 32 showed partial relief within the same time, and subsequent clinical cure.

701358

A clinical cure rate of 97.7%

1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

ABBOTT

Brief Summary on next page

ERYTHROCIN®-SULFAS
Brief Summary

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or newborn infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. of each of sulfadiazine, sulfamerazine and sulfamethazine.

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Lead Paint Poisoning Alert

Baltimore physicians are urged to be alert to the *child lead paint poisoning danger* during the coming summer months. Already in 1967, Jan 1 through May 31, a total of 7 children have been made ill and one case has terminated fatally. During this five month period due to the alertness of physicians or parents an additional 19 children have been found with elevated blood leads and placed under care or treatment.

Lead paint poisoning in Baltimore is no longer a disease of inner city children—cases have been found wherever there are unsupervised young children and homes painted with lead paint. For this reason every child with vague and nebulous symptoms seen by a physician should receive a blood test for lead.

The characteristic initial symptoms are anorexia, apathy, hyperirritability, incoordination and loss of recently acquired skills. The symptoms wax and wane and each episode may readily be attributed to both parent and physician to some intercurrent illness. They may also suggest emotional disorder. If lead ingestion continues the episodes may recur each summer. In this chronic form of the disease without overt encephalopathy a convulsive disorder refractory to therapy and/or signs and symptoms suggestive of cerebral degenerative disease may ultimately appear.

On the other hand, once the early symptoms listed have been present for three to six weeks, acute encephalopathy may occur at any time. In such cases the symptoms intensify gross ataxia appears together with the classic signs of increased intracranial pressure; namely intractable and usually projectile vomiting, lethargy, stupor, coma and convulsions. The risk of encephalopathy is especially great during summer months. A further detailed description of symptoms and diagnostic procedures is described in *Childhood Lead Intoxication: A Preventable Summertime Disease,* by J. Julian Chisolm, Jr., MD, in the July 1964 issue of *Pediatrics Digest,* available from the City Health Department.

It is our hope that physicians will develop a high index of suspicion for lead paint poisoning if a young child is seen with vague symptoms, and a blood test taken. Also it should be noted that cases of lead paint poisoning have ranged from under one year (5 cases) to ten years (2 cases); however most cases occur in the preschool child.

Physicians are advised that blood lead kits are available from the Bureau of Laboratories, Municipal Office Building, Lexington and Holliday Streets. Information regarding blood determinations may be obtained by calling extension 614.

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REHABILITATION Notes

REHABILITATION SECTION
BALTIMORE CITY MEDICAL SOCIETY,

DOUGLAS G. CARROLL M.D.
EDITOR

Physical Therapeutic Methods in Rheumatoid Arthritis of the Upper Extremity

DOUGLAS CARROLL, MD
Chief, Physical Medicine and Rehabilitation
Baltimore City Hospitals

Heat and exercise are the two basic physical methods helpful in the treatment of rheumatoid arthritis of the upper extremities.

Heat:

Heat does not help the very acute swollen joint of rheumatoid arthritis. Heat is indicated prior to exercise therapy in the subacute and chronic stages. In a preventive exercise program to maintain range of motion, heat is indicated to relax muscle spasm.

Various types of heat are available. There is little clear evidence that one type of heat is more effective than another, although many clinicians feel that wet heat is more effective than dry heat in rheumatoid arthritis. Hot packs are particularly helpful in painful shoulder and elbow disease. The arm whirlpool has the advantage of supplying gentle massage and movement of the extremity in addition to heat. The paraffin bath is widely used because a high temperature may be maintained for a prolonged period.

Exercise:

Two important points should be emphasized. First, for exercises to be effective they must be carried out over long periods of time by the patient in his home. This will require good motivation and understanding. Secondly, use of exercise in rheumatoid arthritis is always based on a balance between too little exercise and too much exercise. If the joints are not taken through range of motion sufficiently often, contractures will develop. If the joint is exercised too much, there will be pain and accelerated joint destruction. Isometric exercises (where the muscle is tensed without moving the extremity) is indicated as a measure to maintain muscle strength around joints which are too painful to move.

A routine set of exercises follows. Exercises of lower extremities and neck are included for completeness. These exercises should be modified for the individual patient. As a general rule, application of heat to involved joints prior to exercising is helpful.

It should be emphasized further that it is not enough to hand the patient a sheet of directions for exercises and expect him to carry on. The reasons for exercises must be explained; the patient must be instructed in how to perform them; he must demonstrate that he understands them by performing them; he must be followed at frequent intervals to encourage him to continue them.

EXERCISES FOR RHEUMATOID ARTHRITIS

General Instructions for Exercises:

Conscientious performance of a prescribed exercise routine is of utmost importance in reducing and preventing the crippling effects of arthritis. All exercises must be performed *slowly,* smoothly and very *deliberately.* Attempt to attain as much motion as possible in all directions. Slight pain during exercise is to be expected. Any exercise producing pain later the same day, or persisting the following day, should be reduced. Watch also for increased swelling. Attempt to do the exercises as fully as possible without assistance. Assistance is recommended, however, where active motions are limited. Initially, do each exercise 2 or 3 times each and work up to 5 or 6 times each. Exercise routine should be done at least twice daily.

Fingers:

1. Keeping palm flat on table, raise fingers and lower. Do one at a time, then all together.
2. Make a tight fist; straighten fingers wide.
3. Make an "O" by touching the thumb to all finger tips one by one.
4. Spread fingers as wide as possible; close.
5. Same as 4, except with rubber band entwined around the fingers.
6. Squeeze a rubber ball, sponge, or similar object.
7. Place palms together in front of chest; push against opposite fingers individually one by one.
8. Stretch the fingers as straight as possible. If fingers remain bent, rest hand, palm down, on table. Hold other hand firmly on top of it and raise the forearm of affected hand in an effort to flatten bent fingers.

Wrist:

1. Forearms and hands on table; raise hands, keeping forearms on table. Do with palms up and palms down.
2. Forearms and hands on table approximately 8″ apart with palms flat; without moving forearms attempt to touch index fingers and thumbs of the two hands.
3. Turn palms up, turn palms down.
4. Keeping forearm stationary; turn wrist in circular motion as in stirring a mixture.

Elbow and Shoulder:

1. Touch hands to shoulders, raise elbows.
2. Facing wall; walk fingers up wall.
3. Hands behind neck; move elbows backwards



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4. Raise hands to the side and overhead, touching palms; repeat touching back of hands.
5. Lying on stomach arms at sides and palms up, lift hands and arms directly upwards from the bed, keeping elbows straight.
6. Lying on stomach; pinch shoulder blades together.
7. Elbows bent 90° and tucked firmly against sides; touch hand to opposite arm. Return in opposite direction.

Foot and Ankle:

1. Bend ankle up, down and around in a circular motion. Do clockwise and counter clockwise.
2. Curl toes down; straighten.
3. Standing; go up on toes. Walk on toes.
4. Standing; go up on heels. Walk on heels.

Hip and Knee:

1. Lying on the back; raise feet directly upward, keeping knees straight. Do alternately, one leg at a time.
2. Lying on back; pull knee up to chest, bending knee. Do alternately.
3. Lying on back; spread legs, close and cross ankles.
4. Lying on back; knees straight, roll kneecap inward then outward.
5. Lying on stomach; raise each foot upwards keeping knee straight.

Head, Neck, Spine and Thorax:

1. Bend head forward, backward.
2. Rotate head to sides.
3. Bend head to sides, keeping face forward.
4. Standing, bend body forward, backward and to the sides.
5. Standing without moving feet attempt to turn (rotate) shoulder to side.
6. Breathe deeply attempting to expand the ribs as much as possible. Hold 5 seconds, exhale as far as possible.

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When prescribing, carefully observe dosage recommendations and appropriate precautions, especially as pertaining to the elderly and when complications could ensue from a fall in blood pressure. (See Wyeth literature or PDR as well as "IN BRIEF" below.)

IN BRIEF.

Contraindications: History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. Withdrawal symptoms upon discontinuation have been noted in some patients exhibiting drug dependence through chronic overdose. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose; excessive, prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Withdrawal symptoms following abrupt discontinuance are similar to those seen with barbiturates. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance. Safety for use in pregnancy has not been established.

Not indicated in children under 6 years; absolute dosage for 6- to 12-year-olds not established.

Side Effects: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leucopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age. These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever and euphoria.

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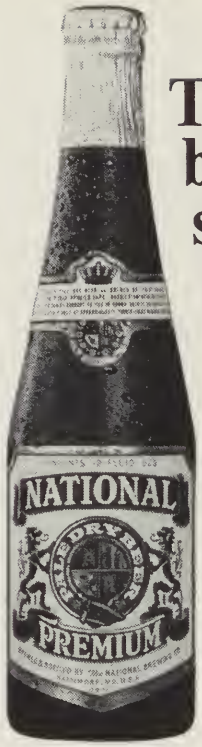
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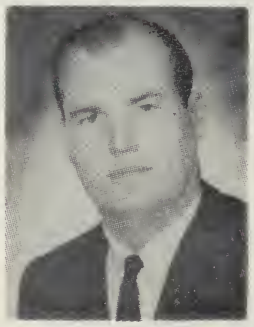
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The Child's Physician And School Mental Health

The acquisition of mental health is not an activity limited to a clinic, hospital or professional office. Mental health should be seen as a potential contribution of all human institutions including the family, the church, community agencies and the school.

Many schools are rapidly increasing their awareness, with programs and an emphasis on their role and techniques in meeting the emotional and social needs of the children enrolled. Educators have recognized the value and relatedness of the child's mental health and personality growth to the total school experience.

Clinical mental health services for adults might be thought of as a *second chance to grow up,* while mental health fostered by the school and family, might be regarded as a better *first* chance to grow up.

Mental health of children is enriched by any experience in which they feel comfortable, accepted and successful. If the school offers the child a sense of challenge, stimulation and achievement, this positive feeling is incorporated into the child's developing personality structure. Much more is learned in school than mere numbers and letters. Personality traits and patterns of appraising and adapting to reality requirements are forming just as surely as are their skills in reading and arithmetic. Unfortunately, far more effort and attention has been given to the latter than to the former. Yet, without the child's subjective sense of purpose, confidence and values, all of the learning tools and contributions of the school may be lost to him and his society.

It is likely that more children with social and emotional problems are referred to mental health specialists by school staff members than by physicians. One reason for this, of course, is that school personnel have the advantage in being able to observe a child over a much longer period of time, both in the course of a day and over a span of months, even years. The school presents what might be considered a *standard stress* situation for all children in requirements for attendance, self-control, achievement, etc. It can be the first place where independent functioning and performance are expected without the presence or support of the parents. The physician, in contrast, only sees the child for a brief period of time and at wide intervals and must rely more on the perception and report of one or both parents. The parents may or may not share with the physician their concerns, if any, about their child's present or anticipated school adjustment problems. The physician should not depend on parents to invariably report emotional, social or behavioral problems occurring in their children at school which in turn jeopardize school attendance, attitudes or achievement. Neither should the physician expect a routine report from the school if his patient is experiencing difficulty there. Parents may not inform the physician of their child's learning or adjustment problems simply because they may not suspect that a given organic or health problem underlies or contributes to them. Some parents are anxious or embarrassed about the lack of progress or the severity of difficulties posed by their children in school and are reluctant to share this

information with others, including their physician.

Many communities in Maryland do not have adequate resources for mental health evaluation or treatment of children. Particularly in those communities, the family physician should be appraised of difficulties in the school and assist the family in coordinating their efforts into finding a suitable school program or placement. The physician may refer the child to sources for more specialized treatment, if these are indicated, available and affordable.

Many schools unwittingly make the mistake of directly referring the family or child to a mental health facility without the prior consideration or support of the family physician. In effect, this action bypasses a person who has been, and will continue to be, a significant and knowledgeable person in the life of the child and his family. Parents will more often accept a referral to their family doctor and his advice regarding the need for more specialized help. The same parents may be reluctant to take their child directly to a mental health professional or facility.

Even when a parent brings his child to the physician and describes a problem in some aspect of the school life of the child, the physician should not accept this as being necessarily a complete or objective report. When there are serious difficulties in school, it would be advantageous to request the parents to have the principal of the school send a brief note directly to the physician giving the concerns and position of the school regarding that patient.

In the course of a routine physical examination or in the treatment of illness or injury, the physician may not be mindful of the possible implications and influence of his findings on the school life of the child. Rather than to wait for a possible complaint relating to school, the physician should routinely ask the parents *and* child about his school adjustment and progress. The simple gesture of the physician's displaying an interest and obviously assigning value to the child's educational experience could, in itself, have a significant effect. Opening questions might be: "How are things going, what activities are you enjoying at school? How is the football team doing this year?", etc.

Any condition in the child, which in the physician's judgment might possibly impair learning or need special consideration, should be shared with the school. Again, this is better sent directly to the school in the form of a brief note than to rely on the parents to report such information. Communication with the school, besides the traditional notes to excuse his patient from physical education or for absences associated with illness, should include the physician's ideas for educational planning and programs commensurate with his clinical observations of that particular child.

For the physician to contribute in a constructive manner, such as to suggest refinements and modifications in a child's school experience, may have a special significance when parents of the child themselves are inadequate, ineffectual or indifferent in seeking a more appropriate school program. The physician, in effect, becomes an advocate for the child in school and shares his suggestions and impressions with the principal or teacher.

The school might be reluctant to call the physician when there is a concern about a child who is his patient because they do not want to interrupt his busy schedule or because of a concern about professional ethics or confidentiality. School nurses and school health physicians often bridge this *communication gap* between the school and private physician. In some communities, however, school health services are minimal or absent. Private and parochial schools in Maryland, with thousands of children enrolled, often do not have the range of supporting services provided by public schools, such as social workers, counselors, nurses and psychologists. For children in these schools, the private physician has far greater significance in his potential to assist the school in its planning and responding to their needs.

There are many ways in which the practicing physician might enhance the school experience for his patients beyond his direct involvement and contribution to a single case. For example, the physician might serve on a committee of his medical society or health department which studies and supports school health services and programs. The physician might volunteer to be a visiting lecturer and participate in health education programs of the school. The physician with children of his own in school may be active in parent groups or in other activities relating to

school. Physicians belonging to community groups and service clubs might support projects aimed at improving the quality of education in local schools. Some physicians offer themselves as candidates for elective school board offices.

Any improvement in school services—the recruitment and retention of qualified teachers, the morale of school personnel, curriculum design, instructional materials, the school health program, the physical environment,—directly or indirectly serves in promoting the mental health of children in these schools.

For the school to know that the child's physician understands and endorses their efforts for his patient, is a great step towards a meaningful physician-school relationship. Textbooks in pediatrics seldom emphasize the importance of such a relationship as being a significant factor in child mental health. For the physician to know that the school is responding to the physical and emotional needs of his patient with a timely and appropriate program, gives him the satisfaction and assurance of having made a positive contribution towards that child's mental health.

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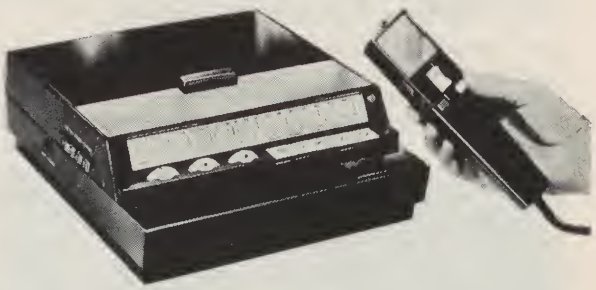
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THE NEUROSES, Henry P. Laughlin, MD; Reese Press, Baltimore.

This publication is especially oriented to the private practice of medicine and psychiatry. Psychodynamics and therapy, and their correlation with today's clinical findings are stressed. The author comments that, "this represents the textbook in extra-mural psychiatry which I very much wanted in my own student days."

We couldn't agree with him more.

It is a book that succeeds the previous publication by the same author, The Neuroses in Clinical Practice published in 1956.

A MANUAL OF TROPICAL MEDICINE, fourth edition, George W Hunter, III, Ph.D.; William W. Frye, MD, and J. Clyde Swartzwelder, PhD; W B Saunders Company, Philadelphia.

This represents an updating of our needs with respect to tropical medicine as they exist today. The three previous publications, originating with World War II, engendered all the knowledge that was existing at that time. This volume brings up to date the information needed by those persons who serve the many undeveloped nations through the Peace Corps, Viet Nam; *AID, HOPE,* and other philanthropic groups.

EMERGENCY CARE OF THE SICK AND INJURED. Robert H. Kennedy, MD; W B Saunders Company, Philadelphia.

This small, illustrated booklet consisting of 128 pages, is primarily a manual for law-enforcement officers, firefighters, ambulance personnel, rescue squads and nurses. Well done under the auspices of the Committee on Trauma, American College of Surgeons, it is a booklet that can be used by all in training courses.

PERIPHERAL ARTERIAL DISEASE, Wiley F. Barker, MD; W B Saunders Company, Philadelphia.

This illustrated book is Volume IV in a series. In it, Dr. Barker concisely reviews the basic pathology and physiology of peripheral vascular lesions, defines the indications for and limitation of corrective surgery and provides practical and up-to-the-minute details of operative technique. This should prove of special value to all whose interest and previous training have drawn them into this rapidly expanding surgical field.

EARLY MANAGEMENT OF ACUTE TRAUMA, Alan M. Nahum, MD; The C V Mosby Company, St. Louis

This book represents an attempt to provide a practical medical background for the physician who is concerned with and responsible for the earliest care of patients who have sustained acute trauma. Emphasis has been placed upon measures necessary to resuscitate and maintain patients without a detailed examination of definitive surgical procedures.

HEMATOLOGIC PROBLEMS IN THE NEWBORN, Frank A. Oski, MD and J. Lawrence Naiman, MD; W B Saunders Company, Philadelphia.

The book's purpose is to provide a single source from which can be drawn what is known concerning the normal and abnormal hematologic processes of the first month of life and the effects of prenatal factors on them. It is a useful guide to all who care for, or are interested in, the newborn infant.

DISORDERS OF CARBOHYDRATE METABOLISM IN INFANCY, Marvin Cornblath, MD and Robert Schwartz, MD; W B Saunders Company, Philadelphia.

This is the third volume in the series of Major Problems in Clinical Pediatrics. The current concepts of the normal and abnormal physiology of carbohydrate metabolism in the fetus, the pregnant mother, the neonate and the infant have been presented as seen by the authors.

HERITABLE DISORDERS OF CONNECTIVE TISSUE, Victor A. McKusick, MD; The C V Mosby Company, St. Louis.

This book is addressed, in particular, to the general practitioner, the internist and the pediatrician. This is because he is in the best position to size up the total situation in the individual patient and with reference to the family background, with which he is most likely to have firsthand familiarity. It is an updating of a series of articles that have appeared in the Journal of Chronic Diseases. It is well-presented and worth reading.

RADIOLOGY IN WORLD WAR II, Kenneth D. A. Allen, MD; US Government Printing Office, Washington, DC.

The volume, part of the series dealing with the US Medical Services in World War II, describes in detail the development of the routine diagnostic use of X-ray under field conditions in disease and in combat and noncombat trauma. The material was provided entirely by medical officers who served in World War II and had first-hand knowledge of the total radiologic experience. Nothing in it is second-hand.

The last chapter unfolds the radiologic story of the Manhattan Project the top-secret World War II project which developed the atomic bomb. Despite what may seem to be a dull subject, this book makes exciting reading.

The Library has one set of the paperbound monthly *Index Medicus,* 1966, which we will be glad to donate to any hospital library lacking this Index. Please request immediately if you desire these issues; otherwise, due to space shortages, we will have to dispose of them.

Woman's Auxiliary
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JULY, 1967

PRESIDENT VISITS COUNTY AUXILIARIES

One of the pleasures that accompanies the honor of serving as President of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland is the privilege of visiting all of the county auxiliaries.

Although I served in this capacity several years ago, it was with great delight that I accepted the invitation of Mrs. Frederick Dove, Jr. to the annual meeting of the Washington County Auxiliary on May 8. There are many changes in the Hagerstown area, new highways, a beautiful addition to the hospital, and it was good to learn that the Alexander Hotel will once again be open to guests.

Washington County is one of our oldest auxiliaries, and has produced three of our state presidents, Mrs. Gerald Levan, Mrs. Robert Conrad and Mrs. Archie Cohen. Throughout the years it has been noted for its outstanding community work in the field of health.

The new officers installed at the close of the meeting at the Woman's Club are: Mrs. Frank Brumback, president; Mrs. Thomas Craig, president-elect; Mrs. John Clark, vice president; Mrs. Edmund Niklewski, recording secretary; Mrs. Edward Ditto III, corresponding secretary; Mrs. Charles Spencer, treasurer; and Mrs. Frederick Dove, Junior Parliamentarian.

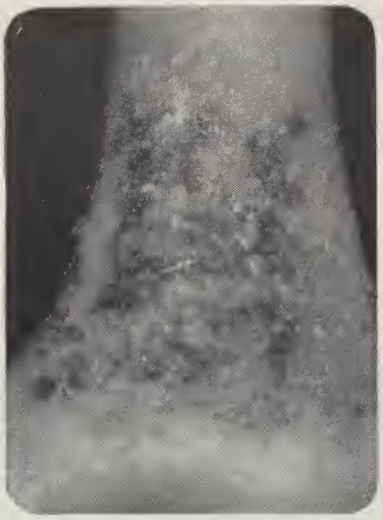
On May 18, I attended the joint annual meeting of the Cecil and Harford County auxiliaries. Mrs. Edgar E. Folk III of Perry Point and Mrs. James Garey of Aberdeen will serve another term as presidents of their respective counties. The activities of these fine doctors' wives in the field of health are notable for their diversification, assistance with the Bloodmobile program, Child Day Care Centers, health careers programs in local high schools, and the support of the local hospital auxiliaries in their projects.



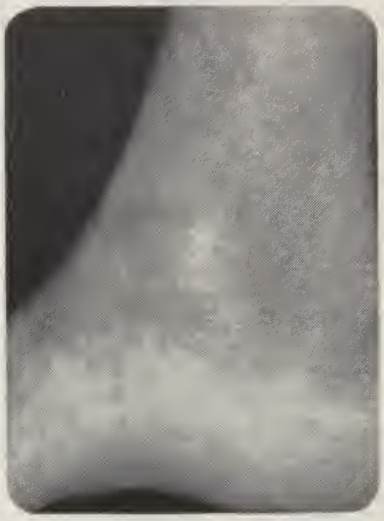
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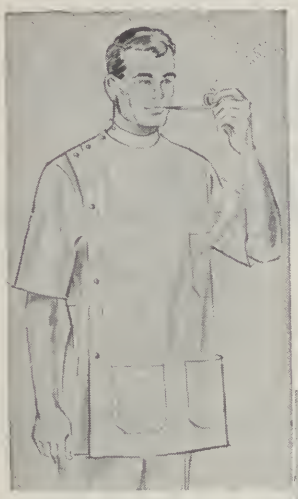
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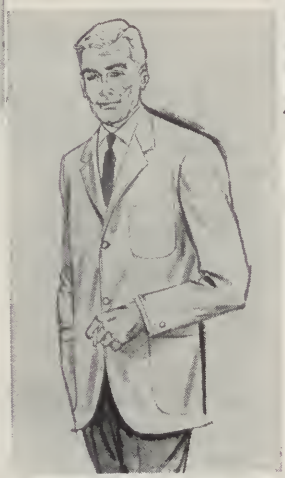
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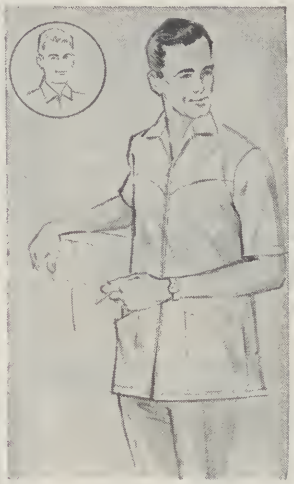
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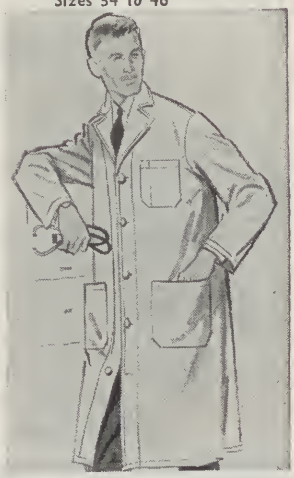
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president; Mrs. James L. Johnson, treasurer; Mrs. Jay S. Barnhart, Jr., recording secretary; Mrs. Hugo P. Silva, corresponding secretary.

Mrs. H. Douglas Cooper, President of the Wicomico County Auxiliary invited me to the annual meeting at the Elks Home in Salisbury on May 23. During my journey I found new highway construction and the meeting place on the edge of a beautiful golf course, just beyond a delightful woodsy park. Salisbury has come into national prominence in the past few years because of the tennis matches held in the Civic Center, and one national magazine said that although the business and civic leaders had a part in bringing the matches to this area, the doctors had been the most outstanding.

Wicomico County is one of our first auxiliaries in the state. The members voted to disband after a short time, but I had the pleasure of attending the meeting of reactivation several years ago. The late Mrs. Kit Hargraves, executive secretary to the medical society at that time, reactivated the auxiliary by enlisting their help in reorganization and cataloging of the Medical Society library. This convinced the members that they were needed and wanted. Mrs. Raymond Yow has served on the state Board as Chairman of Health Careers for several years. The new officers installed are: Mrs. Talmadge Reeves, president; Mrs. Andrew C. Mitchell, vice president; Mrs. Aubrey C. Smoot, Jr., secretary and Mrs. David Shave, treasurer.

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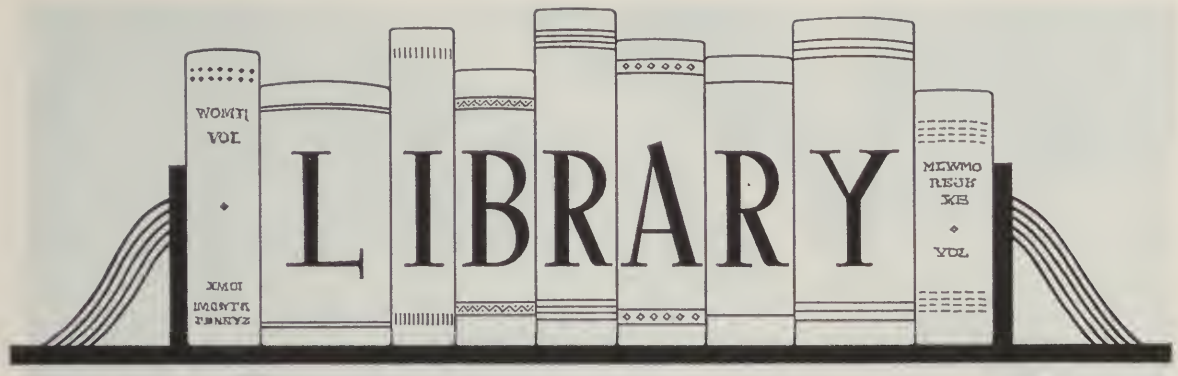
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Summer Projects

Various summer projects are now shaping up in the Faculty library. Mr. Lee Ash, Library consultant, will return to continue his survey of the library's collection, with the help of extra personnel employed for the summer months, to follow up on processing the books after he has indicated the proper disposition.

Another note of progress occurred when the National Library of Medicine notified Mr. John Sargeant that this library is eligible for consideration for a construction grant. The next approval of applications will be November 1, 1967. These grants are awarded on a matching basis to applicants able to meet the requirements of the Medical Library Assistance Act of 1965.

During the Special Libraries Association meeting in New York City, May 28-June 1, Mrs. Elizabeth Sanford visited the New York Academy of Medicine for a short tour conducted by Miss Gertrude Annan, Director, and attended a dinner meeting later. Prior to that a tour and reception was held at the Medical Research Center of New York. This is a cooperative activity of several member libraries in the area providing a depository for both books and journals, with direct *TWX* communications between about ten of the participating libraries. The operation is located on the sixth floor of a garage building which the Center has purchased.

On Thursday morning buses were provided to transport librarians to the Medical Research Center of Brooklyn. Here the Academy of Medicine of Brooklyn, Downstate Medical Center, and Joint Library of the State University of New York have been combined. Mrs. Helen Kovacs, Librarian of the Downstate Medical Center presented the program, with film explaining the workings of the library for their borrowers, followed by a TV presentation of some of the computerized operations. These two audio-visual aids had been produced very reasonably by the library center with the help of the components staffs. After an elegant buffet luncheon this session resumed with a discussion on Regional Planning.

The Annual meeting of the Medical Library Association was held June 11-18, Miami, Florida and reports on these sessions will appear in later issue.

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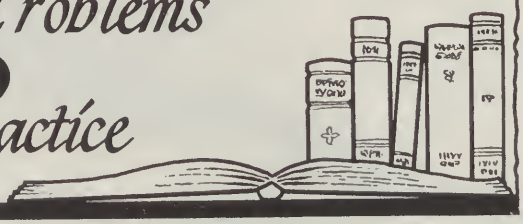
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ALL ABOUT AIDES-PART III

By Wilburn L. McClure, Jr.

Ways to Keep Valued Aides

The best ground rules one can use toward keeping valued employees are:

1. Maintaining mutual respect; and,
2. Conscientiously fulfilling the obligations one has to the other.

It is probably safe to say that most doctors believe that their aides are "the best in the business." However, far too often doctors fail to communicate this feeling to their aides. The lack of such overt praise leaves the employee in doubt regarding the respect her employer has for her responsibilities, quality of work and general value to the practice.

The devotion to duties, loyalty to the doctor and years of service to the practice demonstrate the respect and fulfillment of obligations most medical aides provide to physicians.

Review the following categories with your aides and see if each has a firm understanding as to the obligations one has to the other.

Duties:

Does each aide have some type of guide to act as a check list which will help her in understanding the task assigned, the order of importance and when they are to be completed if special circumstances prevail? Does she have some type of instructions concerning emergency situations? Has she been briefed on the limits of her authority? Is there a plan to bring such a check list up to date periodically?

Hours:

Have you defined the routine office hours of your practice? Does your aide know what to expect when overtime is necessary?

Salaries:

Do you have a defined salary scale or is it one that is made up as time goes by? Do you have a firm basis for giving future raises, such as a merit system, longevity system or a discretionary system?

Vacation:

Have you outlined when your aides can expect to have their vacation and how long it may be in accordance with their length of employment with the practice?

Sick Leave:

Do you provide allowances for sick leave with pay up to a certain limit, and without pay up to another limit? Do you have a system for account-

---

Mr. McClure is director of the Baltimore office of Professional Business Management, Inc. This monthly column is prepared as a complimentary service to the *Maryland State Medical Journal.*

ing for sick leave? Does your aide know what to do toward finding a temporary replacement when sick leave occurs?

Holiday Routine:

Do you have a specified list of regular and special holidays? Is there a long range plan for merging *special time off* with holidays when a holiday falls on a Friday or a Monday?

Fringe Benefits:

Do you, or should you, provide uniform allowances? Do you provide health insurance? Do you encourage additional schooling and membership in special associations which would enhance the proficiency of your aides? Do you pay for their parking? Is there a bonus system?

A semi-annual *mutual ventilation* conference is a good idea for every practice. This is true if it is a one-girl office or a twenty-girl office. The more employees you have, the more need you have for such conferences in order to gain a collective review of the administrative side of the practice.

The more interest you take in your aides, the more interest you will find that they will take in you and your practice. No one likes to be taken for granted or considered as a necessary evil.

Give your aides credit when credit is due. Give them criticism backed only by facts. Encourage them to discuss whatever problems they have as soon as possible. When you receive the request for such a meeting, grant it immediately under the most ideal conditions possible.

When you feel you have conscientiously fulfilled your obligations to the aide, but you are not receiving services required, contemplate replacing the aide. But, before you do that, you may wish to read next month's column.

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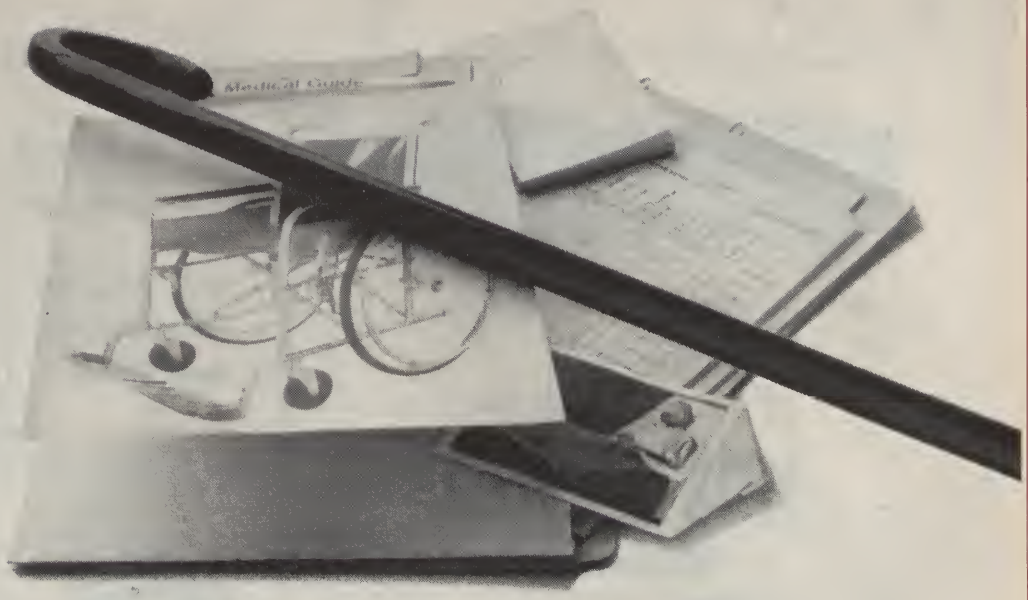


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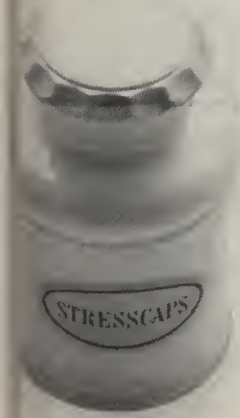
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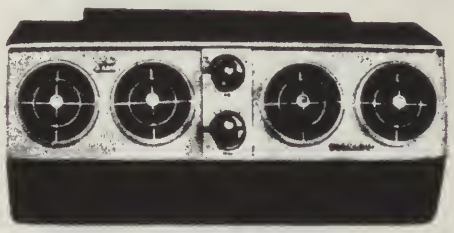


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WASHINGTON COUNTY

The Washington County Medical Society held its regular meeting at the Venice Restaurant on Thursday, May 25. **John C. Stauffer, MD** spoke and showed films on his recent experiences in Africa, where he took part in a project sponsored by Operations Cross Roads Africa, in cooperation with the Nigerian government's Ministry of Health. Since it was Ladies' Night, the wives enjoyed sharing this interesting program with the doctors. **Mr. and Mrs. John Sargeant** were guests of the local society for this meeting.

Mr. and Mrs. Robert Chatkins of Hagerstown were also present as guests on that evening. Mr. Chatkins is a pharmacist and was given a certificate by the Washington County Medical Society for outstanding service to the community and the physicians over the years.

* * * * *

The members of this Medical Society cooperated with the local health department to immunize as many children as possible in Washington County on End Measles Sunday, May 14. Some 2,735 area children were vaccinated.

* * * * *

In March the Auxiliary to the Washington County Medical Society held its annual Health Careers Day. Part of the program were tours of Western Maryland State Hospital and Washington County Hospital. **I. B. Lyon, MD,** Chief Physician, greeted the guests at Western Maryland State Hospital.

* * * * *

On Saturday, April 1, **John C. Stauffer, MD** and **James Dobbie, MD** took part in the Cumberland Valley Athletic Club's Fifth annual John F. Kennedy 50-Mile Hike. Dr. Stauffer shared fourth place with an excellent 11 hour 16 minute clocking. This was his third straight completed hike. Dr. Dobbie clocked 14 hours and 30 minutes and completed his second straight hike. Our congratulations to both of these fine physician athletes.

Dr. Stauffer also took part in the running marathon in Boston later in April.

* * * * *

Louis G. Graff, MD and **Edward W. Ditto, III, MD** attended a Post Graduate Medical Study at the University of Kansas Medical Center in Kansas City, Kansas, April 16-19. Their interest was in anesthesiology.

Lloyd Hoffman, MD and **Edson B. Moody, MD** attended a Seminar of the Northern Virginia Heart Association held in Washington D.C. in April. **John H. Hornbaker, MD** attended the American College of Physicians meeting in San Francisco, April 10-14.

John W. Clark, MD

* * * * *

BALTIMORE CITY

Board of Directors Meeting

Seven members of the Board of Directors of the Baltimore City Medical Society, were present at the monthly meeting held May 9, 1967, at 1211 Cathedral Street, Baltimore, Maryland. The meeting was called to order by the President, Harry J. Connolly, MD. A reply from Roy F. Perkins, MD, Director, Department of Health Case Services AMA, regarding the Society's interest in health manpower in the state of Maryland was

read. He pointed out that several states have indeed instituted active efforts to study local manpower conditions. Perhaps the largest such program is in California with the establishment of a Health Manpower Council. This was established as a voluntary agency to coordinate efforts in recruitment, training, and utilization of health manpower in the state. The Council states that its interest will also include environmental as well as personal health.

A problem case was referred to the Board from the Professional Relations Committee by Martin Singewald, MD. Similarly, a "problem case" was brought to the attention of the Board by R.C.V. Robinson, MD. Both complaints were referred to the State Board of Medical Examiners. Frank Kaltreider, MD, proposed that cocktails and dinner be served prior to the Society meetings with the hope of increased attendance. Martin Singewald, MD offered an alternative approach, it being to utilize various community hospitals for meetings—thus obviating the parking problem, a deterrent to good attendance. John C. Harvey, MD, voiced the opinion that this possibility also offered the likelihood of physician unification. John Wiswell, MD, stated that the Policy and Planning Committee is presently undertaking an active study relative to increasing attendance at Society meetings.

Frank Land, MD, formerly a GP, has been appointed to the Dept. of Health Education and Welfare as Director, Division of Family Services. His sole role will be with Title XIX. Mr. Sargeant advises that Dr. Land suggested meeting with BCMS. Mr. Sargeant also advises that Dr. Land will be in Baltimore to speak to the Faculty Fee Schedule Committee, May 24th.

The Board was pleased with a favorable reply to its support of Operation "Reason," from Senator Joseph Tydings. The Senator informed the Board that $300,000 has been appropriated by the Economic Opportunity Committee for the support of Operation "Reason." H. Doyl Taylor, Esq., Director, Dept. of Investigation, A.M.A., urged the Board to bring to the attention of the membership, that a very active department of the A.M.A. is involved in the investigation of problems of "Quackery." Members are urged to report their suspicions to this department.

Dr. John C. Harvey called the Board's attention to the recent Public Law 89-749. This law demands that the states formulate "one agency" to control all federal money appropriated to the state for health programs. Dr. Harvey stressed that this agency is soon to be formed and that the Society should inform the Governor of its interest in the planning and function of this agency. The Board unanimously supported this stand.

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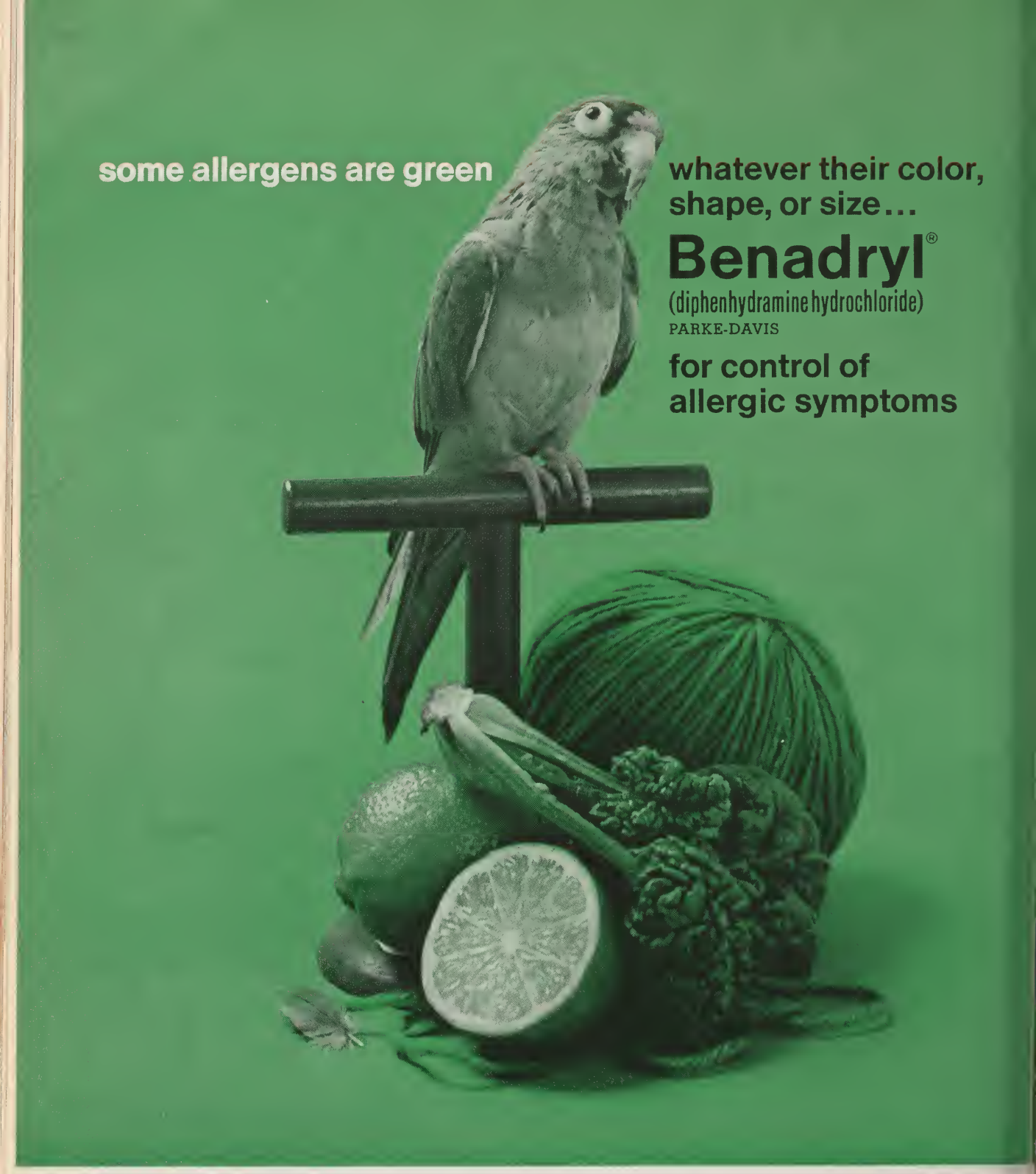
Vol. 16, No. 8
August, 1967

SEMINAR FOR PRINCIPAL NURSING HOME PHYSICIANS

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AMERICAN COLLEGE OF PHYSICIANS

September 18-21, 1967

Postgraduate Course—Hemotology: Current Concepts ond Developments. University of California Center for Health Sciences. Los Angeles, Colifornia. Contoct: Edward C. Rosen, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine St. Philodelphio, PA. 19104.

AMERICAN CANCER SOCIETY NATIONAL CANCER INSTITUTE

September 20, 1967

Symposium on Acute Leukemia and Burkitt's Tumor held ot the Boston Museum of Science, in Boston, Massachusetts. Contact: Jock W. Milder, Americon Cancer Society, Inc. 219 East 42nd St. New York, N.Y. 10017.

AMERICAN COLLEGE OF CHEST PHYSICIANS

September 21-23, 1967

Post Graduote course on Cordiopulmonary Problems in children. Holiday Inn, Chicago. Ill. Contoct: American College of Physicions, 112 Eost Chestnut St. Chicago, Ill. 60611.

AMERICAN MEDICAL WRITERS ASSOCIATION

September 21-24, 1967

27th Annual Meeting of the Americon Medical Writers Asociotion—Polmer House, Chicago. Contact: AMWA, P.O. Box 267, Arlington, Va. 22210.

AMERICAN MEDICAL ASSOCIATION COUNCIL ON OCCUPATIONAL HEALTH

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AMA Volunteer Physicians for Viet Nam is a program for supplying medical care to the civilian population of South Viet Nam through the volunteer services of US physicians.

It is administered by the *AMA* and financed by the United States Agency for International Development (*USAID*).

Physicians sent to South Viet Nam under the program serve a 60-day tour to duty at one of 16 provincial civilian hospitals. The volunteer receives only his transportation and an expense allowance of 10 dollars a day; otherwise his services are entirely unpaid.

At the hospitals the volunteers will work with teams of military physicians and corpsmen. These teams, assigned to *USAID* for service in provincial civilian hospitals, provide continuity in the volunteer program.

Twenty-four to 32 physicians are needed every month to keep hospital staffs at full strength. Most needed are general practitioners, internists, general surgeons and orthopedic surgeons. As of June-July, 1966, the greatest demand is for general and orthopedic surgeons to treat war wounded civilians. Small numbers of specialists in the fields of chest diseases, ophthalmology, otolaryngology, radiology and psychiatry are needed from time to time. Other specialists cannot be used at present but inquiries are invited in anticipation of future demands. Because of conditions in Viet Nam only male physicians are accepted. Non-physicans are not recruited.

Information about the program may be obtained by contacting:

AMA Volunteer Physicians for Viet Nam
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THE BACKGROUND:

Twenty-five years of war and insurrection in the area now known as South Viet Nam has placed tremendous health burdens on the people. To the ever-present diseases and malnutrition of Southeast Asia have been added war injuries, disruption of whatever public health measures existed, and a serious lack of doctors and nurses as more and more of the country's approximately 1,000 physicians were called into military service. Today only about 350 physicians are left to administer health care to 15 million Vietnamese civilians.

South Vietnamese authorities have asked the US government to encourage American physicians to volunteer their services to Vietnamese civilians.

Out of this request grew a program financed by the US government through the State Department's Agency for International Development (*AID*). Created to recruit US physicians for volunteer 60-day tours of service at Vietnamese civilian hospitals, the program was at first administered by People-to-People Health Foundation, Inc., with the *AMA* assisting in recruitment. At this point the program was called *Project Viet-Nam.*

After successfully implementing *Project Viet-Nam* on a pilot basis, People-to-People Foundation asked that the program be turned over to some other responsible agency, preferably the *AMA*. At the invitation of the Agency for International Development, the *AMA* assumed administrative responsibility on June 30, 1966, when the contract between the *USAID* and People-to-People Health Foundation, Inc. terminated. Under the aegis of the *AMA*, the program is known as *AMA* Volunteer Physicians for Viet Nam.

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Diseases causing disability throughout the population include trachoma (four-fifths of the people infected at one time or another), leprosy, bacillary and amebic dysentery, smallpox, and nutritional disorders.

South Viet Nam has about 120 hospitals, of which 101 serve civilians. All are overloaded; at times, two or even three patients have been accommodated in a single bed.

Physicians serving through *AMA* Volunteer Physicians for Viet Nam are placed in government-operated hospitals in rural areas, where the need is greatest. All are in so-called pacified regions where the Viet Cong do not routinely conduct military operations in the open, although they are presumed to be nearby at all times.

Military teams in the civilian provincial hospitals will each comprise three medical officers, one administrative officer, and twelve enlisted men (corpsmen). Their responsibility will be for the civilian population in the province to which they are assigned.

RECRUITMENT:

To be accepted as a volunteer the physician must be in good health and not more than 55 years old. No dependents may accompany the volunteer, even if the dependent is medically qualified.

A passport and visa are required of all volunteers going to Viet Nam, and assistance is given the physician in obtaining them. The volunteer also must have a certificate of vaccination against smallpox and inoculation against cholera, received in the last four to six months. Immunization against plague, typhoid, tetanus, typhus and polio are recommended by *WHO*.

Transportation is supplied from the physician's home to Viet Nam and return. A standard baggage allowance of 44 pounds, plus an additional 22 pounds, is permitted.

Housing is provided in Viet Nam in available hotels or apartments. Each volunteer physician receives an expense allowance of 10 dollars a day. Expenses connected with passport, visa and immunization are paid by *USAID* through *AMA* Volunteer Physicians for Viet Nam. Each volunteer is covered, while in Viet Nam, by a $50,000 all-risk insurance policy at no expense to himself.

Upon arrival in Saigon the volunteer will be met by the Field Director of *AMA* Volunteer Physicians for Viet Nam or an associate, and directed to the proper destination. The Field Director also assists hospital staffs with supply and logistical problems.

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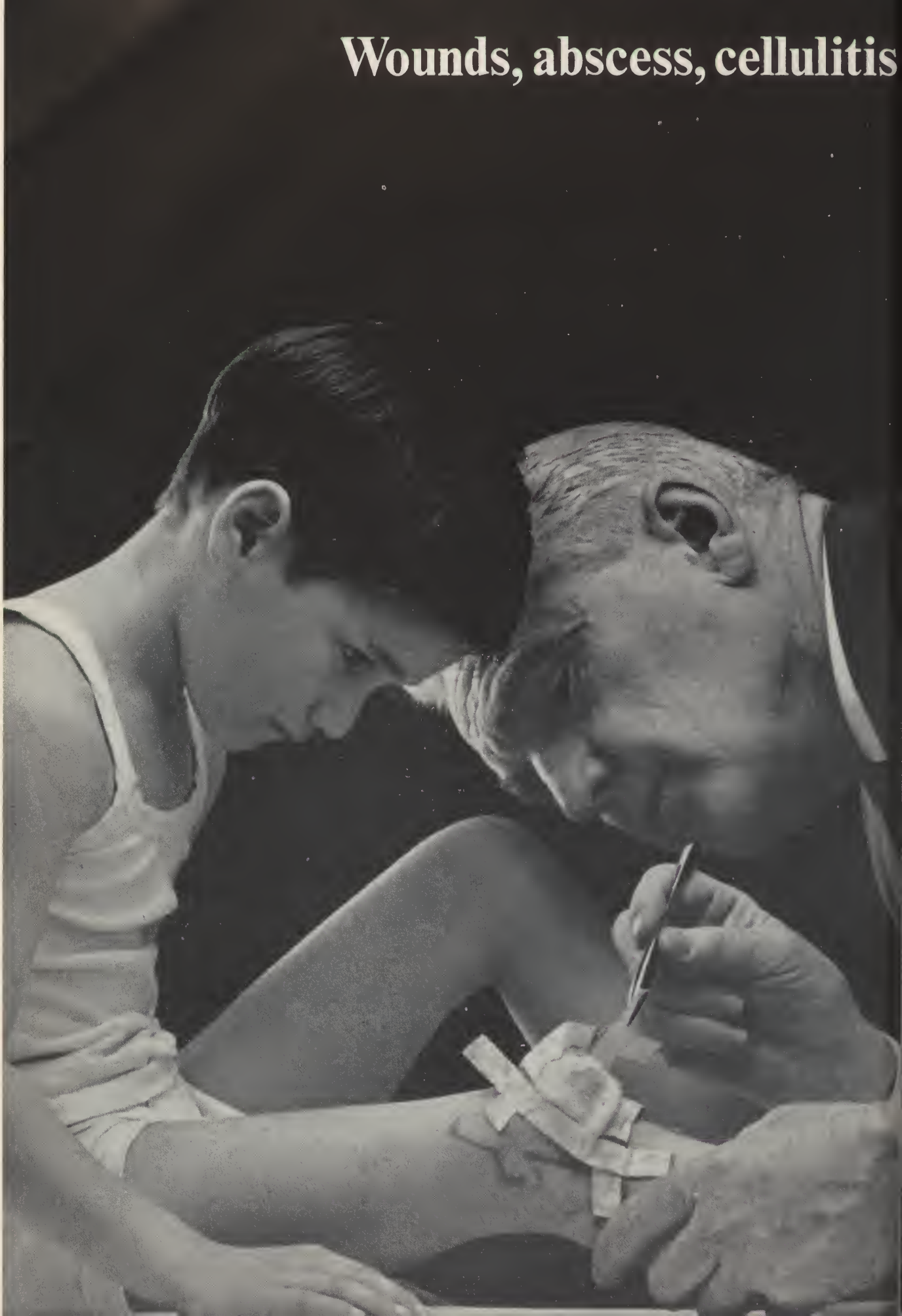


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References: 1. Abstracted from *Antibiotic Sensitivity of Staphylococci Studied from November 1962 through August 1965*, reported by Griffith, L.J., Staphylococcus Reference Laboratory, V.A. Hospital, Batavia, N.Y. 2. Data on file, Bristol Laboratories.

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Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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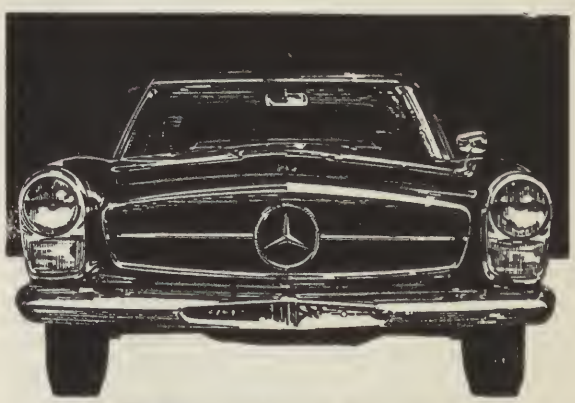
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EXECUTIVE SECRETARY'S NEWSLETTER

August, 1967

SEMIANNUAL SESSION

Plans are now complete for the Semiannual Session of the Faculty in Ocean City on September 8 and 9. Meetings of various specialty groups are also scheduled during these two days.

Headquarters for the meeting is the DIPLOMAT MOTEL, 26th & Boardwalk, Ocean City, Md.

Full details on the sessions are in the mail to all members.

ANNUAL MEETING AND CRUISE CONVENTION

The 1968 Annual Meeting is scheduled for April 17 to 19, followed by a Cruise Convention aboard the SS Argentina, April 21 to 28. Reservations for the cruise convention may be made during the Ocean City meeting.

NEWS NOTES

Donald B. Cheek, M.D., Baltimore, has been selected to receive the 1967 Borden award of the American Academy of Pediatrics.

Donald K. Wallace, M.D., Baltimore, recently began a two-month tour of volunteer service to the civilian population of South Viet Nam under the auspices of the AMA Volunteer Physicians for Viet Nam program.

Leonard Scherlis, M.D., and Thomas Connor, M.D., have both been named full Professors at the University of Maryland School of Medicine.

Jess V. Cohn, M.D., Baltimore, has been reappointed Editor of the NEWSLETTER of the Association of Medical Superintendents of Mental Hospitals.

Martin J. Birnbaum, M.D., Baltimore, has joined the offices of Drs. Copeland, Hyman, Shackman and Stofburg, in the practice of diagnostic and therapeutic radiology.

Harold Rosen, M.D., Baltimore, has written a book that went to press recently and is scheduled

for publication in the fall. Its title is ABORTION IN AMERICA.

RUBELLA ALERT PROJECT

The State Health Department is sponsoring a Rubella Alert Project. Its purpose is to determine the number of children born following the Rubella epidemic of the 1964 winter who have handicaps as a result of their mothers having rubella during the pregnancy.

It is hoped to identify the children clinically so as to determine the diagnosis and attempt remedies prior to reaching school age.

It is hoped that physicians will cooperate in this mass program and identify the children clinically for the State Department of Health's rubella registry.

AMERICAN MEDICAL ASSOCIATION MEETINGS

Once again, physicians throughout the State are reminded that they have the opportunity to to speak before the various Reference Committee meetings of the AMA on any subject in which they might be interested.

Unfortunately, it is not generally realized that all physicians, whether they be AMA members or not, have this privilege.

In this manner, a complete cross-section of opinion on subjects of major importance can be obtained.

AMA CONFERENCE

A regional Conference, for Maryland and surrounding states, on Aging and Long-Term Care has been scheduled for November 2 - 3 at the Emerson Hotel, Baltimore. The conference is sponsored by the AMA Committee on Aging. Interested parties should contact the Faculty office for further information.

John Sargent
Executive Secretary

Pages 19-20 missing

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PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

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MEDICAL NEWS

From Baltimore



JOHN M. DENNIS, MD

John M. Dennis, MD, Baltimore, will assume office as a Councilor of the Medical and Chirurgical Faculty at the conclusion of the 1968 Annual Meeting. Dr. Dennis represents the Central District along with others from that area.

Dr. Dennis is currently the Professor of Radiology and Head, Department of Radiology at the University of Maryland School of Medicine. A native of Maryland, he obtained his BS and MD degrees from the University of Maryland, where he also interned and completed his radiology residency. He served for an additional year as a Fellow in Radiology at the Hospital of the University of Pennsylvania.

From 1946-48 he served in the US Army as Chief of Radiology at the Station Hospital, Langley Air Force Base, Virginia.

He is the author of numerous publications and has served as an officer of the American College of Radiology; Maryland Radiological Society; Maryland Division of American Cancer Society; and the Medical Board of the University of Maryland Hospital.

From Washington

AMERICAN MEDICAL ASSOCIATION TO SPONSOR NINTH NATIONAL CONFERENCE ON THE MEDICAL ASPECTS OF SPORTS

The Ninth National Conference on the Medical Aspects of Sports, sponsored by the AMA under the auspices of its Committee on the Medical Aspects of Sports, will be held in Houston, Texas, at the Hotel America on November 26, 1967. The Conference is held annually in conjunction with and on the first day of the Clinical Convention of the AMA.

As was true of the previous eight Conferences, the Ninth will cover a wide range of subjects of interest to those serving school and college athletic programs. Included will be forums and discussion sections relating to prevention of knee injuries, sports cardiology, and quackery in sports. Two sessions will be devoted to a series of common clinical conditions of rather variable significance in the athletic setting (eg., gastroenteritis, concussions, genitourinary tract injuries, and rib injuries). At the Conference Luncheon, Eduardo Hay, MD, Director General of the Centro Deportivo Olimpico Mexicano, will discuss the preparations for the 1968 Olympic Games.

The Conference is open to key non-medical athletic personnel as well as interested physicians. Those who would like to receive further information concerning the Conference should address the Committee on the Medical Aspects of Sports, AMA, 535 North Dearborn Street, Chicago, Ill. 60610.

* * * * *

John W. Gardner, secretary of Health, Education and Welfare, called on the medical profession and others in the health field to "search for new and less expensive ways of doing things."

This was the main theme of his talk at the

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windup session of a two-day National Conference on Medical Costs attended by 300 physicians, hospital administrators and other leaders in the various aspects of health care. He said the conference discussions "reflected a universal recognition that change is necessary."

"We cannot go on as we have in the past," Gardner said. "New patterns will be necessary. Those who entertain some apprehension as to what the new patterns will be had better plunge in and experiment with their own preferred solutions . . . Standing back and condemning the solutions that others devise won't stem the tide of change. . . .

". . . . there is not yet any agreement as to what a more perfect system would look like. It seems likely that we will go through a period of experimentation and in true American fashion may end up with several variations in different parts of the country, suiting local preferences and conditions.

"Whether the health care system or the future should develop around the hospital as an organizational focus, or around the payment mechanism, or around group practice plans, or around all of these in some sort of collaboration with State health planning councils—or whether other variants will emerge—is still a wide-open question. . . .

"Essentially . . . the challenge is before the health profession. They must join the search for solutions. They must be willing to re-examine and overhaul long-established practices. The search for new and better and less expensive ways of doing things must be carried on by hospitals, medical schools, community agencies, and by the thousands of individual physicians serving the health needs of people. . . .

Acceptance of such responsibility by those in the private sector, Gardner said, "is the best insurance against the government having to shoulder more than its share of corrective measures."

Citing appointment of an advisory committee to study hospital effectiveness, Gardner said that *HEW* will do its part in the search for more efficient practices. The committee is to report by the end of this year.

Dr. Milford O. Rouse, president of the *AMA*, commended the Administration "for showing its concern for rising health care costs by calling a national conference on the problem.

"The American Medical Association and its member physicians pledge to accept their responsibilities in finding solutions to this vital problem," he said. "We expect that other full members of the health team—dentists, hospitals, nurses, pharmacists and pharmaceutical companies, the insurance industry and others—will do likewise.

"We hope the Administration will also accept its responsibility to find ways to ease the burden of inflation which contributes substantially to inflating the cost of medical care. We hope the Administration will call a moratorium on new health legislation until existing programs can be critically evaluated to eliminate overlapping and duplication and to achieve maximum conservation of tax funds. We hope available tax money, particularly in the health field, can be used to help those who really need help while allowing our more fortunate citizens to accept responsibility for their own care."

* * * * *

Congress passed and President Johnson signed into law a bill that extends the program of grants for the construction of community health centers for three years.

It authorizes the appropriations of $50 million for fiscal year 1968 and $70 million for 1970.

The amended law also extends the program of grants for the initial staffing of community mental health centers for an additional two years (until 1970) and authorizes the appropriation of $26 million for fiscal 1969 and $32 million for fiscal 1970. An appropriation of $30 million already was authorized for fiscal 1968.

* * * * *

President Johnson signed into law legislation extending the draft for four years. It includes a provision continuing special pay for physicians and dentists.

The new law also continues the authority to defer medical students until completion of internship. In the future, foreign physicians in this country will be liable to draft up to age 35—the same as for Americans. Under the old law, foreign physicians were exempt from age 26.

The present blanket military exemption for Public Health Service officers serving on loan to other agencies such as Food and Drug Administration was removed despite protests by the agencies involved. Such assignments with draft exemption can now be made only to the Coast

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Guard, Bureau of Prisons and Environmental Services Administration. The *AMA* had asked Congress to allow no draft exemptions for non-military service.

* * * * *

The President of the *AMA* said that Sargent Shriver, Director of the Office of Economic Opportunity, was in error when he accused the *AMA* of being opposed to medical care for the poor because the *AMA* is opposed to the *OEO's* slum health care centers.

Milford O. Rouse, MD, Dallas, Texas, the *AMA* president said the *AMA* is opposed to the *OEO* projects because the health care problems in the slums can be taken care of under existing programs, particularly *Medicaid.*

"There is already too much proliferation of wasteful, overlapping federal health programs," Dr. Rouse said.

"Also of concern to physicians is the fact that at times it seems that government is too quick to set up health care programs without consulting with those who know most about health care—physicians."

The *AMA* president also said Shriver was misinformed about *AMA's* position on helping those who need help.

"I am now and always have been in full accord with *AMA's* long-standing position that those who need help in financing health care should receive it," Dr. Rouse said.

"The *AMA,* however, is opposed to the doling out of tax funds to the wealthy and well-to-do. The expenditure of public funds for those who can well afford to finance their own health care limits the amount of resources available to those who do need it. Such a policy cannot be justified morally or economically."

THE WORLD MEDICAL ASSOCIATION, INC.

Individual membership in the World Medical Association is now open to all members of the American Medical Association.

Dues are $10 per year. This includes a subscription to *World Medical Journal* and the privilege of participation in the World Medical Assem-

bly each year.

The 21st World Medical Assembly will be held in Madrid, Spain, September 10-17, 1967. The 1968 Assembly will be held in Australia.

The World Medical Association is a society of the free, professional medical associations of the free nations. Sixty national medical associations are members, including the *AMA*.

The 20th *World Medical Assembly* last winter in Manila created for the first time an individual associate membership within the *WMA*. Members of the national medical associations may now join *WMA* as individuals.

Gerald D. Dorman, MD, of New York City, member of the *AMA's* Board of Trustees, is Chairman of the Council, governing body of the *WMA*. The *WMA* Headquarters Secretariat is located at 10 Columbus Circle, New York City. Secretary General is Alberto Z. Romualdez, MD.

Application for individual membership may be made to *WMA* at the New York City office. Applications should be accompanied by a check for $10, with a statement that the applicant is a member in good standing of *AMA*. The letter should specify whether the applicant wishes to receive the *World Medical Journal* in the English, Spanish or French language edition. Checks should be made payable to *The World Medical Association, Inc.*, a tax-exempt organization. Five-year memberships are available for $50. Information regarding the 21st *World Medical Assembly* will be mailed promptly to all applicants for individual membership.

"The World Medical Association," said Dr. Dorman, "is uniquely qualified to act as a force for peace and understanding in the world today. *WMA* is a very real and vital part of the world health picture, continually seeking to solve world medical problems through the community spirit and action of its professional membership."

Dr. Dorman made it clear that *WMA* has no connection with any government, that it is committed to the philosophy that medical and scientific knowledge should be universally available and free of all political control.

The *WMA* is present at conference tables around the world where decisions are made affect-

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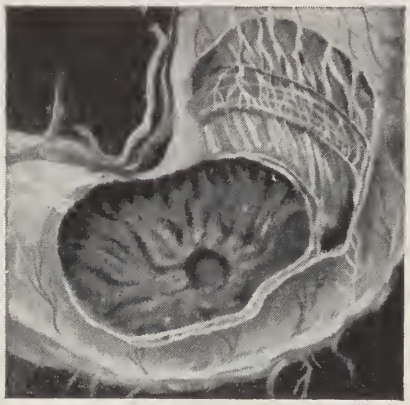
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ing the practice of medicine—and where the practicing physician's free enterprise viewpoint would not ordinarily be considered, he said.

"Thanks to *WMA,* the individual doctor has an effective, recognized international voice in health and professional matters now being considered by such government organizations as the World Health Organization (*WHO*), United Nations Educational, Scientific and Cultural Organization (*UNESCO*), International Labor Organization (*ILO*), International Social Security Association (*ISSA*), and other governmental and non-governmental bodies."

WMA was organized in 1947. In 1965 it was incorporated as a non-profit educational and scientific organization under the laws of New York State, *USA*. With incorporation of *WMA* it was possible to obtain tax-free status recognition on funds donated to the organization.

PRACTITIONER-TRAINEE FELLOWSHIPS

Radiotherapy Fellowship for the Practicing Radiologist

A one-month Fellowship in radiotherapy is available immediately under the auspices of the Georgetown University Medical Center and under the direction of J. Robert Andrews, MD, Director of Radiotherapy at the Center and Chief of the Radiotherapy Section, Washington Veterans Administration Hospital. The Fellowship is designed as a refereshser experience in radiotherapy for the general radiologist doing radiotherapy in community hospitals. The Fellowship will stress practical aspects of cancer radiotherapy and will include operations with X-ray and cobalt-60 machines, orientation in cancer chemotherapy, and participation in tumor clinic conferences.

Cancer Chemotherapy Fellowship for the Practicing Physician

A one-month Fellowship is available to practicing physicians in the field of cancer chemotherapy. This is designed for interested physicians in all fields who would like to obtain experience with standard and investigational chemotherapeutic agents as well as with the special aspects of the care of cancer patients on an oncology service and in clinics. These programs are in progress at the District of Columbia General Hospital, the Veterans Administration Hospital, and the George-



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town University Hospital under the direction of Bruce I. Shnider, MD, Professor of Medicine, Director, Division of Medical Oncology, Department of Medicine, and Chairman of the Eastern Cooperative Oncology Group. Dr. Shnider is assisted in this program by Drs. G. Lennard Gold, Clinical Associate Professor of Medicine, John J. Lynch, Clinical Instructor in Medicine, and Pedro Matias, Instructor in Medicine. Fellowships are available for a one-month period.

Fellowship in the Practice of Nuclear Medicine

A one-month Fellowship in nuclear medicine is available immediately at the Georgetown University Medical Center under the direction of August Miale, Jr., MD, Director of the Radioisotope Unit. This program is designed to present more recent advances in the use of radionuclides in the diagnosis of cancer. Particular attention will be directed to the use of new instrumentation such as the scintillation camera for both static and dynamic studies of various organ systems. The Fellowship is best suited for those individuals practicing nuclear medicine particularly in community hospitals where such techniques have only recently been introduced. Previous experience in radioisotopes with licensure under the Atomic Energy Commission or State Boards is a prerequisite.

Fellowship in Surgical Oncology

A one-month Fellowship in surgical oncology is available under the direction of John F. Potter, MD, Associate Professor of Surgery and Head of the Division of Oncologic Surgery. The program includes refresher experience in the clinical diagnosis of malignant neoplasms and in the scope and techniques of appropriate surgical biopsy. The principles of current surgical treatment and observation of cancer operations are included in the program. Participation in clinics and cancer conferences is included.

For further information contact J. Robert Andrews, MD, Co-Director of the Program, Georgetown University Medical Center, Washington, D. C.

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Your MEDICAL FACULTY at Work

JOHN SARGEANT EXECUTIVE SECRETARY

The Executive Committee at its July 13 meeting took the following actions:

1. Supplied a list of three names to the State Health Commissioner from which he will select a Faculty representative to serve on the Advisory Council to the Regional Medical Programs.

2. Approved cruise convention allowances for the 1968 Cruise Convention.

3. Endorsed a State Health Department project to seek out the children born following the 1964 winter rubella epidemic so as to, "identify the children clinically, educate the public to be aware of the problem and seek early medical care, and to mobilize the Heath Department and educational facilities to meet the diagnostic and educational needs of these . . . children."

4. Approved minor changes in the rate structure of the Faculty's Professional Liability program.

5. Heard that the appeal of Leonard Flax, MD, against the decision of the Executive Committee to a six-month suspension of Faculty membership had been denied by the AMA Judicial Council.

6. Deferred discussion on the newly proposed Rehabilitation Center on Montebello Hospital grounds until the medical director of this Center could be present to discuss it in detail.

7. Established a Liaison Committee with the Health Department so as to promote more effective "cooperation, candor and confidence," between the two groups, especially in connection with the Title 19 program.

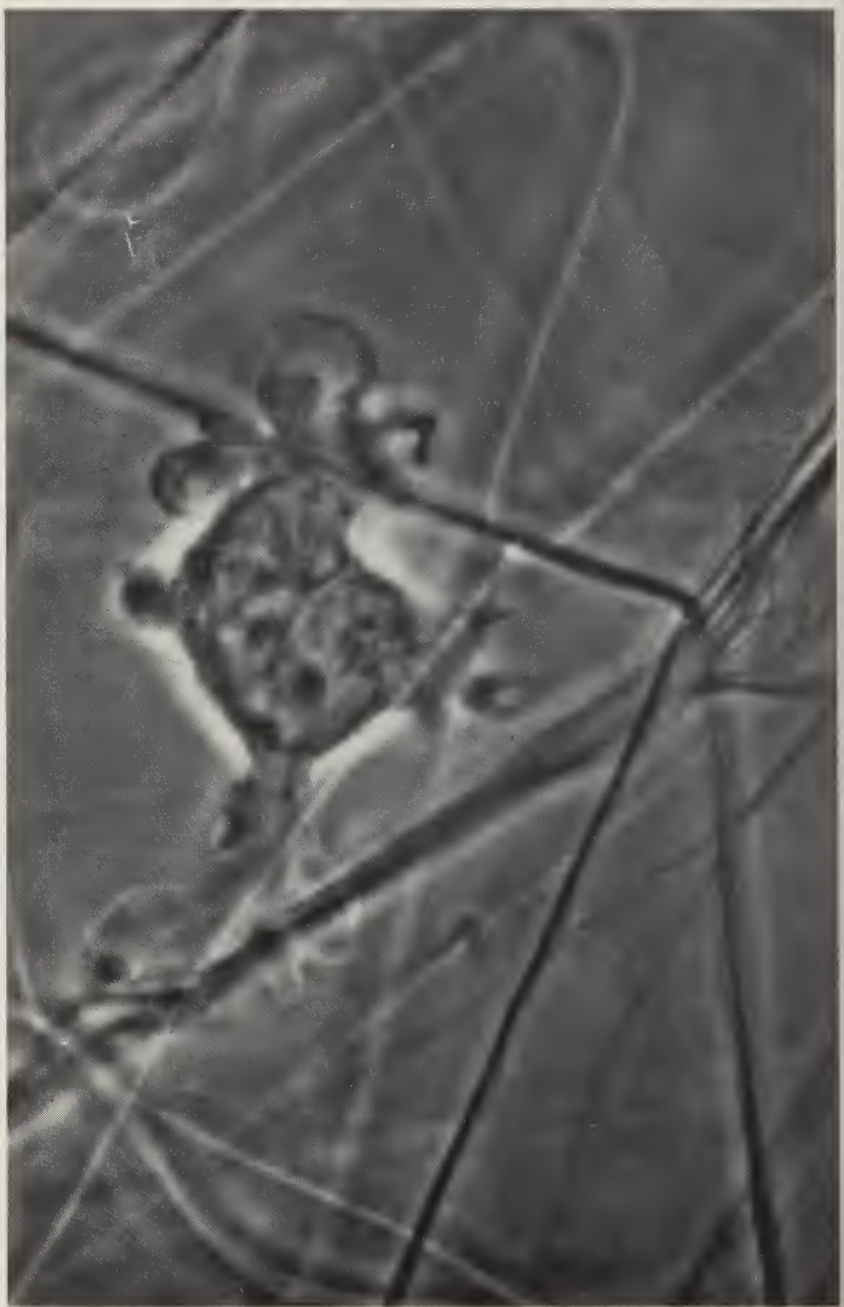
8. Approved mailing of a joint letter to be signed by the AMA President, the Faculty president and Component Presidents in connection with medicine's future.

INFLAMMATION:
A cellular fight for life

A SYNTEX REPORT based on recently developed hypotheses about topical corticosteroids, including the cellular theories of inflammation by Thomas F. Dougherty, Ph.D., University of Utah.

You are looking at a fibroblast fighting for life. This cell—one of the most common found in connective tissue—has literally been poisoned by cytotoxins released from other cells that have ruptured. Soon, if the abnormal activity of this fibroblast does not cease, it, too, will rupture and die—one more casualty in the inflammatory wave of destruction precipitated by injury.

Until a short time ago no one had ever witnessed such a scene at the cellular level. Now, through advanced cinemicrographic techniques, it is possible to view and photograph the inflammatory process as produced experimentally in living animal tissue. This method permits new insight into the mechanism of inflammation and the role of corticosteroids in therapeutic management. Equally important, these techniques shed new light on factors that may make one corticosteroid more effective than another—factors that can be correlated with other chemical, biologic, and clinical parameters.

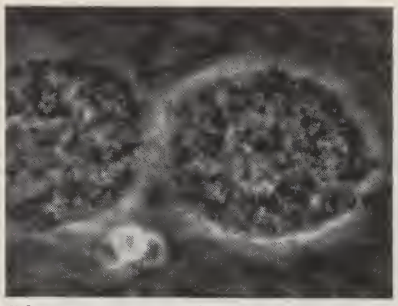


Visual evidence of how corticosteroids influence the inflammatory reaction

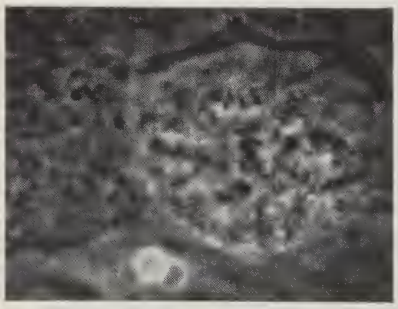
Working with phase-contrast cinemicrography on living animal tissue, Doctors Thomas F. Dougherty and David Berliner of the University of Utah College of Medicine have actually filmed cellular events that occur during the inflammatory reaction. This remarkable study* and additional work by these investigators, as well as by others, have established a new theoretical biologic basis for the antiinflammatory effect of the corticosteroids. (It must be noted that other theories, such as the lysosome or so-called "suicide bag" theory, have been postulated, although it is quite likely that there are more similarities than differences among the various theoretical models.)

The inflammatory wave of destruction

In this investigation an injurious injection of gelatin is used to set off an inflammatory reaction in living mouse tissue. What follows is a wave of destructive cellular activity that comprises the inflammatory response to injury. Mast cells (which contain heparin, serotonin and histamine) take up water, swell and rupture, releasing their contents, which are toxic outside the mast cell wall. These toxins, in turn, cause disintegration of other cells (such as fibroblasts) and the release of additional toxic material. Capillaries, too, take up water and leak unformed blood elements, causing edema. And polymorphonuclears, lymphocytes and perithelial cells invade the inflamed site. As a result of all these changes, the cellular environment reaches a state of turmoil.



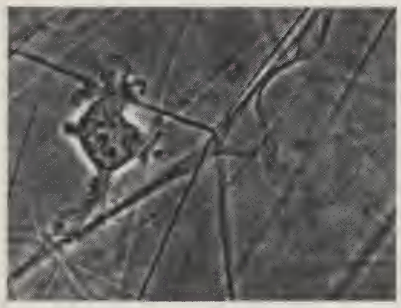
Phase-contrast microscopy showing mast cell before injury.



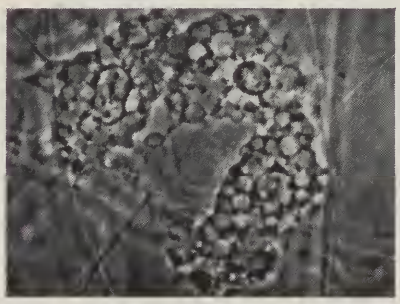
Mast cell (after injury) has broken up and released cytotoxins.

How corticosteroids change the picture

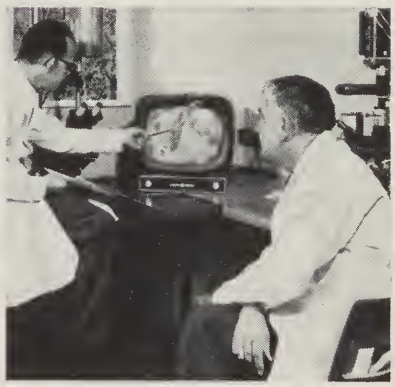
Corticosteroids appear to virtually stop the abnormal cellular activity that constitutes the inflammatory reaction. This permits the body's natural resources to clear up the inflamed area and repair the damaged tissue. This interpretation is supported by the fact that when the injurious gelatin solution is injected simultaneously with a corticosteroid —Synalar (fluocinolone acetonide)— the inflammatory pattern simply does not develop.



Fibroblast in high state of activity, much distorted.



Mast cells showing effects of corticosteroid action: cells are normal in size, shape and activity.



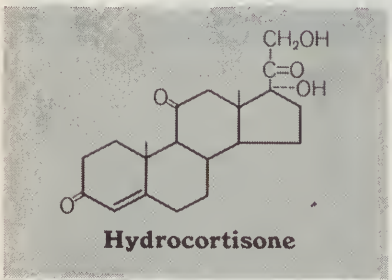
In summarizing his study Doctor Dougherty states: "...we also feel this work may explain why one corticosteroid helps a patient more rapidly and effectively than another. If it does, it is because one corticosteroid is the fastest, most effective inhibitor of the series of inflammatory events at the tissue level."

*A New View of Corticosteroid Action in Inflammatory Dermatoses, a film based on this study, is now available from your Syntex representative.

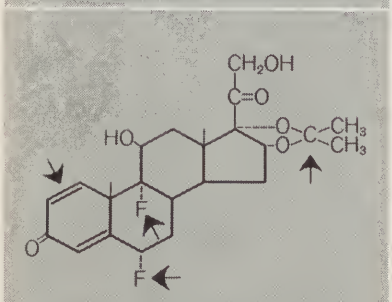
See last page for contraindications, precautions, side effects and dosage.

How advances in chemical design have achieved greater steroid potency

The chemical modification of corticosteroid molecules from the advent of hydrocortisone to the development of Synalar (fluocinolone acetonide) is a prime example of how biochemists can "design" to increase therapeutic activity and minimize undesirable side actions. Below, for example, we see the important changes that were made in reference to the hydrocortisone molecule to produce fluocinolone acetonide, one of the most active of all topical corticosteroids. As a result, a 0.01% preparation of Synalar (fluocinolone acetonide) has been reported to do the work of a 1% hydrocortisone product containing 100 times more cortiscosteroid. And it can often do it more effectively.



Hydrocortisone

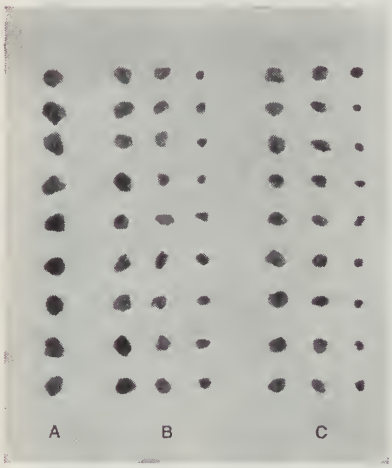


Fluocinolone Acetonide (Synalar)

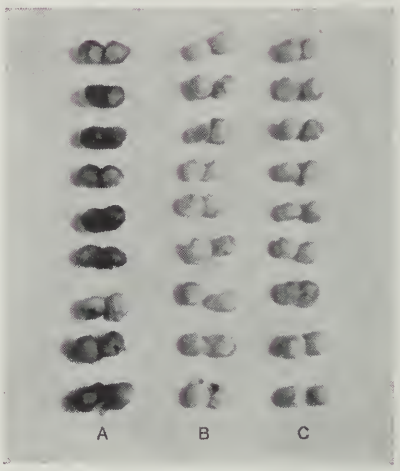
- ☐ *a double bond between carbons 1 and 2*
- ☐ *fluorine substitutions at* both *the 6-α, and the 9-α positions*
- ☐ *the addition of the acetonide at the 16-α, 17-α positions, thus providing one of the most potent topical corticosteroids available.*

How bioassay tests are used to "predict" therapeutic potential

Biologic assays are another tool used by researchers to help establish the relative activity of corticosteroids. To date no single method of assaying corticosteroid activity has emerged as the ideal "yardstick" for predicting therapeutic potential. Taken together, however, these methods have proved useful. When such tests are run on various corticosteroids, a definite order of corticosteroid activity becomes evident. Compounds with the highest order of activity may be expected to merit clinical trial to establish their high therapeutic potential. When assayed by these methods, fluocinolone acetonide (Synalar) emerges as one of the most active topical corticosteroids, milligram for milligram, available for clinical application today.



THE THYMUS INVOLUTION ASSAY[1-4] is run on adrenalectomized rats. The sizes of the glands are measured, and the degree of involution caused by the steroid is determined as an indication of its potency. In the above photo, the comparative involution of thymus glands achieved with hydrocortisone and Synalar (fluocinolone acetonide) is shown. Untreated controls (A) show normal size. Group B—injected with 1, 2 and 4 mg. of hydrocortisone—show progressively smaller thymuses as does Group C—injected with fluocinolone acetonide—but with only 1/500th the dose of hydrocortisone.



THE ANTIGRANULOMA ASSAY[1-4] also utilizes adrenalectomized rats. Granulomas are induced by subcutaneous implantation of cotton pellets on either side of the thorax. The degree of granuloma inhibition achieved by a steroid reflects its potency. The above photo shows the inhibition of granuloma formation achieved with hydrocortisone and Synalar (fluocinolone acetonide). Untreated controls (A) show large, red granulomas adhering to the pellets. Group B, receiving hydrocortisone and Group C, receiving fluocinolone acetonide, show little, if any, granuloma formation. Fluocinolone acetonide produced the same effect as hydrocortisone with only 1/500th the dose. This assay, as well as the thymus involution assay, measures systemic rather than topical corticosteroid activity. Nevertheless, results by these methods correlate well with other assays and with the milligram potencies of topical steroids in current clinical use.

Worldwide clinical experience confirms the predictable therapeutic potential of Synalar

It is particularly gratifying that the promise of the advanced chemical design and high order of bioassay activity of Synalar (fluocinolone acetonide) has been confirmed by widespread therapeutic application. Indeed, the impressive clinical response rate of Synalar has been documented in no fewer than 232 papers from 22 countries.

Representative Clinical Results with Synalar*

Efficacy Documented in over 4,000 Patients

Condition	Number of Publications	Number of Patients	Significant Improvement†
Contact Dermatitis	27	750	713
Eczematous Dermatitis	21	472	409
Seborrheic Dermatitis	18	442	426
Atopic Dermatitis	24	460	426
Psoriasis	36	1,699	1,510
Neurodermatitis	18	351	324
Total	144	4,174	3,808

*Complete bibliography on request.

†Expressed by the authors as excellent, very good, good, complete remission of inflammation, etc.

PRESCRIBING INFORMATION

For initiation of therapy: Cream 0.025%, 5 and 15 Gm. tubes, 425 Gm. jars; *for emollient effect:* Ointment 0.025%, 15 Gm. tubes; *for maintenance therapy:* Cream 0.01%, 15 and 45 Gm. tubes, 120 Gm. jars; *for intertriginous or hairy sites:* Solution 0.01%, 20 cc. and 60 cc. plastic squeeze bottles; *for infected inflammatory dermatoses:* Neo-Synalar® Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes.

CONTRAINDICATIONS: Tuberculous, fungal, and most viral lesions of the skin, (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. PRECAUTIONS: Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. When severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. SIDE EFFECTS: Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. The neomycin in Neo-Synalar Cream rarely produces allergic reactions.

REFERENCES: 1. Lerner, L. J., Bianchi, A., Turkheimer, A. R., Singer, F. M., and Borman, A.: Anti-inflammatory steroids: potency, duration and modification of activities. Ann NY Acad Sci 116:1071 (Aug. 27) 1964. 2. Idem: Comparison of anti-granuloma, thymolytic and glucocorticoid activities of anti-inflammatory steroids. Proc Soc Exp Biol Med 116:385 (June) 1964. 3. Ringler, A.: Activities of adrenocorticosteroids in experimental animals and man, in Dorfman, R. I.: Methods of hormone research, New York, Academic Press, 1964. vol. III. pp. 234-280. 4. Gubersky, V. R.: To be published.

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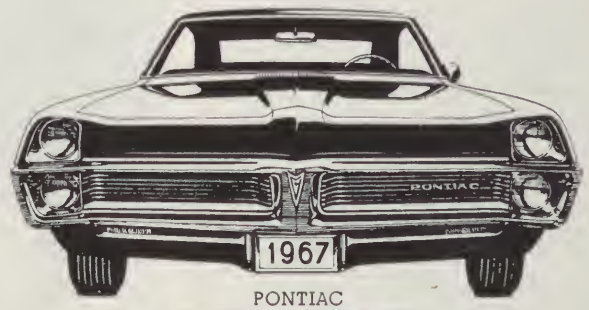
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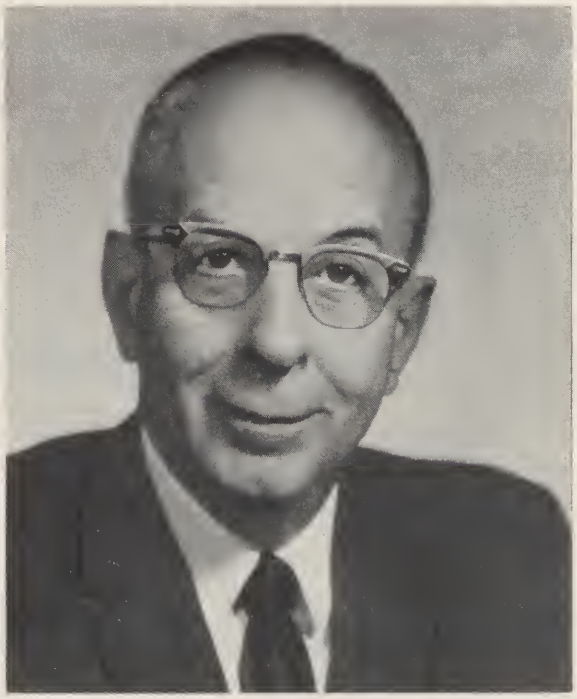
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AMA PRESIDENT 1967-1968



MILFORD OWEN ROUSE, MD

Milford O. Rouse, MD, Dallas, Texas, took office as the Association's 122nd president in June, 1967, for a one-year term.

Before being named president-elect in 1966, Doctor Rouse served as speaker of the House of Delegates from June, 1963, and as vice-speaker in the preceding four years.

He was born in Jacksonville, Texas, August 10, 1902, the son of a Baptist minister, teacher and author.

Doctor Rouse graduated from high school in Vernon, Texas, and took three degrees at Baylor University—the AB, MA and eventually MD—from its College of Medicine in 1927. He interned at Ft. Sam Houston Station Hospital in 1972-28 and has practiced in Dallas since 1928, specializing in gastroenterology.

Since 1943, Doctor Rouse has been clinical professor of medicine (gastroenterology) at the University of Texas Southwestern Medical School. He previously taught at Baylor University's College of Medicine when it was located in Dallas.

Doctor Rouse was married in 1927 to a Baylor classmate, Leaureame McDavid of Henderson, Texas. They have one daughter, Mrs. C. L. Sawyer of Fort Smith, Arkansas, and three grandchildren.

Dr. Rouse has contributed more than a score of papers and medical articles to journals throughout the country. He is a past president of the Dallas Southern Clinical Society, the Texas Society of Gastroenterologists and Proctologists, and the Texas Medical Association. He was Councilor from Texas in the Southern Medical Association 1950-1955, Chairman of the Council in 1955, and was president of Southern in 1958-1959.

He is a member of the Texas Academy of Internal Medicine, Texas Geriatric Society, the Dallas Academy of Internal Medicine, the American Gastroenterological Association and the American Therapeutic Society. He is a diplomate of the American Board of Internal Medicine and the subspecialty Board of Gastroenterology, and a life fellow of the American College of Physicians.

Doctor Rouse is a charter member of the board of trustees of the Dallas Health and Science Museum, and is currently its vice president. He received the first Health Award of the Dallas Hospital Council in 1947. The Southwestern Medical Foundation gave him a special award in 1945. He received the first Distinguished Alumnus Award of the Baylor Medical Alumni Association in 1964, the Distinguished Service Award of the Texas Medical Association in 1964, and the Distinguished Service Award of the Southern Medical Association in 1965.

Dr. Rouse is a 32nd degree Mason in Scottish Rite, a member of Hella Temple, the Knights Templar, the Optimist Club, and the Phi Chi medical fraternity. A deacon in the Lakeside Baptist Church in Dallas, Doctor Rouse teaches an adult men's Bible class. He is a director of the Rio Grande National Life Insurance Company of Dallas. He was named Dallas' man of the year on January 1, 1967.

SEMINAR FOR PRINCIPAL

Greetings

J. Morris Reese, MD

This committee originated in a very casual manner. After one of the meetings of the technical committee attended by Dr. Peeples, we were discussing many extraneous matters, and out of that discussion arose the idea, to discuss this topic which I am sure you realize is coming more and more to the fore.

The purpose of establishing the Planning Committee for Principal Nursing Home Physicians was to plan for a general discussion of the problems encountered by nursing homes, and to try to do something about upgrading the quality of the care, and to discuss the role the physician should play in this regard, the responsibility of the physician in improving quality of care in nursing homes, and the responsibility of nursing homes also. So we have a dual purpose here today.

A committee was chosen to represent the principal nursing home physicians and the State Health Department. I really want you to know that is an *ad hoc* committee at the present time. They have done a tremendous amount of work, and have certainly been anything but derelict in their duty. That is why we are here today.

Their discussions have included many subjects,

Purpose Of Seminar

I want to express my appreciation for this show of interest in a subject that I think we are all very much interested in. I feel if nursing home care is really to be improved, you are the ones who could most likely bring about this improvement through your interest, through your practices, and through bringing about improved practices of caring for patients in nursing homes.

Admittedly, in many cases, care of the older patient is not a very rewarding type of experience, but nonetheless it is a branch of medicine, and it is going to be an even more essential branch of institutional care in the future than it is now.

I believe the only way that quality can be improved is if you physicians, who have patients in nursing homes, or who are principal physicians, taking care of State-aided patients in nursing homes, insist upon quality medical care. Then those patients will begin to get quality type services.

Last summer we had a physician make a study of some of the nursing homes here in Baltimore City. He picked a sample of 250 state aided patients out of a total of some 1200 to 1400 patients in the city, compared these in a degree with some private patients who were in nursing homes, and found some very startling facts.

Many of these patients had absolutely no notes, no diagnosis, no written orders. Only six of fifteen diabetics had ever had a urinalysis. Four-

NURSING HOME PHYSICIANS

expressing concern about the rise in nursing home costs which follow the establishment of requirements for additional services, such as social workers, record librarians, and so forth.

There was discussion of the role the present nursing home will play under *Medicare*. Many will not qualify as "extended care facilities" under Title 18. In fact, only about 20% of the present nursing homes could qualify under present federal law.

Under discussion here today will be the role of the principal nursing home physician, his responsibility for overall standards of patient medical care, and his responsibility for continually reviewing patient admissions, their care, and their discharge, with the intent of continuous upgrading of care.

Drug policies, training of staff, emergency procedures, food service, and the composition and economics of utilization review committees will also come under discussion.

We thank you for taking time from your already overcrowded schedules to attend, and I am sure you will find this time well worthwhile.

Thank you very much for being with us.

William J. Peeples, MD

teen percent of those who were diagnosed as having hypertension had never had a blood pressure recording.

Deaths after admission to nursing homes—and certain nursing homes were worse than others—were startling in that they occurred usually one to two weeks after being admitted. Patients who had come from hospitals, where one might think they might have had a good workup, were no better. The workups were no better than those referred from private physicians, when the hospital had many more facilities and many more opportunities to conduct diagnostic types of procedures. This is but a small example of what can occur.

Further, there was evidence that some 33% of the patients who were evaluated did not really need nursing care. I am sure you are aware there are many patients in the homes you serve who are there because they need custodial care, but don't necessarily need nursing care.

If you think the rest of the *Medicare* program is snarled up, the nursing home part of this program is just as confused, if not more so than the rest of it. For instance, the Federal Welfare Agency has decreed that all patients who are under the medical assistance program in this State, and other states, can only be cared for in homes which meet extended care facility standards.

As Dr. Reese said, this would constitute about

20% of the total number of nursing homes as a potential. There are others which have the potential of qualifying, but there are some 60 or 70 homes which have no real potential for qualifying, and in these homes there are over a thousand medically-aided patients.

It is hopeful that the welfare agency will change the deadline on this requirement and allow an evaluation of patients who are in nursing homes to determine whether they need medical assistance, just a certain amount of nursing care, or other medical attention, or whether they do not need any of these.

We hope you will join with us in making these evaluations. If the patient does not need nursing care or other medical procedures that can be carried out in the nursing home, then some other place can be found to take care of the room and board requirements of this patient.

If he does need skilled nursing care, then I believe the Federal Welfare Agency may change its policies and go along with present arrangements possibly until 1969. That is, there would be two levels of care: one is extended care; the other is chronic nursing home care, pretty much along the lines that have been drawn up in the regulations newly adopted by the State the first of this year.

You know we appreciate the services of the principal physicians, and appreciate your being here. I hope that this will be only the first of many discussions that will be concerned about the care of nursing home patients.

Role of the Principal Nursing Home Physician and Upgrading of Care

Raymond T. Benack, MD

What I will say today will provoke some anxiety in a few and great concern in many. However, we are entering a new era of patient care, and because of this, changes must be made, new responsibilities delegated and new roles assumed in the continuing care of the chronically ill.

In my short life span, and in my even shorter period of medical practice, I have seen nursing homes change from old, dilapidated, overcrowded, unsanitary and unsafe buildings, where patients were sent to die or be forgotten; to homes which are magnificent modern edifices with carpeted halls, beauty salons, and the latest in rehabilitation equipment. Unfortunately, I have not seen the physician's interest in the nursing home patient keep pace with the improved facilities.

We must now meet because of federal and state legislation to better define the role of the private physician and his relation to the nursing home patient. But before one can do that we must first clarify the role of the Principal Nursing Home Physician who will act as consultant to the private physician and the nursing home administration.

We cannot blame the physician alone, nor the nursing home administrators, nor even the federal or state governmental agencies. The problem is bigger than any one of them can resolve alone. So let us recognize from the beginning that every human being in need of, or receiving care in, a nursing home, is dependent upon all of us working together. If the physicians, nursing home administrators, or the governmental agencies fail in their respective role in the upgrading of the quality of patient care in nursing homes, then we will all fail.

When we fail the patient suffers. When the patient suffers, we must answer not only to ourselves, to our fellow physicians, or even to civil courts, but above all we must answer to God. We are given the opportunity to work together towards the ideal in nursing home care. If you fail to make the most of that opportunity, you violate the natural law. Violation of the natural law is answerable ony to God.

During the past year I spent over three hundred hours seeing patients in nursing homes. When you

are in a nursing home for that much time, you have to see and hear things. Much of what I have seen and heard would make you wonder how some people continue to survive. It is difficult for me to understand how the average nursing home patient can suffer from eight or more diseases, and still be seen once every three or four months.

Would a physician who is a patient in a nursing home be expected to be seen every three or four months? Would he accept the same care for his parents? Each patient must be considered as our own parent, and we should provide him with the same care we would expect or desire. The family and relatives have entrusted to us the care of that patient, expecting the best possible care, that is, the care you would expect for yourself or your own relatives.

It is now necessary for the principal physician in the nursing home to assume a new role, and new responsibilities to accomplish these goals. In assuming this new role, we must also give him a title which would more adequately clarify his position. I would prefer to call such a physician the *Medical Director* of the nursing home. The reasons for this will be amply demonstrated in the subsequent discussion. Most obvious will be the fact that the principal physician will not only be responsible for the care of those patients without attending physicians, or for emergencies, but also will be expected to develop, revise, enforce and continually evaluate medical policies for the institution.

What then is the role of the principal physician. The *Medicare* law states that the extended care facility must have a physician responsible for the execution of patient care policies, and that the facility have a physician available to furnish necessary medical care in case of emergency.

The new State of Maryland regulations governing nursing homes define the duties of the principal physician as "responding to calls at times of emergency, and being available as needed to advise the administrator on medical questions. He shall also provide guidance on the execution of patient care policies and the health program of employees."

If we develop these brief guidelines into the more specific responsibilities which they encompass, we will find that they require a great deal of time and effort on the part of the principal physician. The principal physician must develop medical policies in conjunction with the administrators and director of nursing. These policies must include not only a guideline for physicians, but also those policies necessary to insure optimum and continued use of the facilities.

The *Medicare* law and the State laws clearly define the frequency with which a patient must be seen, and what information must be available and when. My concern is what happens during the first 48 hours, or when the physician fails to provide the necessary information, or to see the patient with the frequency required. Therefore, the medical policies must not only include the listing of information already prescribed by law, but also include a description of the absolute minimum of information about the patient's illnesses, drug and other allergies, idiosyncrasies, unusual behavior, therapy, diet, and what particular care problems he or she might have.

It is not sufficient to know only that a patient has a hip fracture, particularly if he has heart disease or mild diabetes, or is disoriented at times. Any one of a number of emergencies can occur within the first 24 to 48 hours for which the physician may be called. Lack of basic information about all the patient's illnesses may lead to a patient's discomfort or even death. The physician should not depend upon the family or the patient; they may be no more informed, or equally as confused as you.

We must remember that most of the regulations spelled out in the *Medicare* law should not only be applied to *Medicare* patients, but should also include all nursing home patients. Therefore, the policies you outline should be applicable to all patients. For this reason you must develop a system to advise physicians when they are delinquent or fail to abide by the regulations. How would you go about this?

There is one method in which an initial telephone call is made to the physician. If he fails to follow up on that, then a letter is sent, with a check-off system whereby the administrator advises the private physician of what regulation he has failed to follow. Also, it should be clearly written down what steps must be followed by the adminstrator when the attending physician has failed to fulfill his obligation, after adequate notification.

I do not believe that the medical director should be responsible for informing the attending physician. Even though it is a medical policy, it is also a law which must be followed by the nursing home in order for it to retain its license. Also, many patients select the medical director as their private physician when their private physician cannot see the patient. Consequently, it would be unwise for the medical director to advise the private physician of his loss of privileges, when the medical director has an excellent chance of being asked to assume the patient's care. This obviously opens the door to many accusations and potential unethical practices.

The medical director should evaluate the facilities, equipment and services. He should make recommendations to the administrator wherever patient care might be improved. This includes even improvements in the building or maintenance policies, since these are often important to patient care. Inadequate physical therapy space, or lack of adequate light, even unusual odors, excessive heat, poor ventilation, insufficient recreation areas, are all an integral part of patient care. What good is a physical therapist if he has no room or equipment to work with? What good is an occupational therapist if she has no equipment?

The medical director also should insure proper diet therapy. He should check the kitchen, check diets, check the distribution of food. I have seen regular coffee, fried foods, given to patients on a bland diet. I have seen trays of food sit in corridors, becoming cold, while waiting for staff to distribute them. I have seen dirty kitchens, food stored in dirty storerooms, and disheveled, unkempt and occasionally drunk staff preparing meals.

Take an occasional trip through the kitchen, check the quality of food being prepared, walk into a patient's room at meal time, and see if the food served corresponds to the diet prescribed. If you have the intestinal fortitude, sit down sometime and eat the food. (You might be surprised; it might be good or bad.)

With the cooperation of a pharmacist, prepare guidelines for drug control. This includes not only the standard regulations as they pertain to identification of patients' drugs, but also such policies as they may pertain to drugs to be included in the emergency tray, such as digitalis, coumadin, pronestyl, adrenalin and similar drugs. Make sure that it contains drugs for all emergencies, not only cardiac emergencies.

There should be drugs for treatment of insulin shock, blood loss, acute pulmonary edema, regardless of cause. This tray should be on every wing or floor. Only one tray for the home with a few wings or floors is impractical. When an emergency occurs you don't have time to run around for drugs.

In connection with the emergency drugs, you should have clearly defined procedures to follow in case of emergencies. This should include not only immediate nursing procedures, but also procedures to be followed in contacting private physicians or, in their absence, the medical director. Delay may mean the difference between life and death. Waiting for a physician who is attending a meeting to call you back may take too long. It may be easier to contact the medical director or his alternate.

Despite what some may say, there should be a group of drugs available in the home which can be used when pharmacies are closed, or when delivery will be delayed. If I prescribe a drug stat, I mean stat. When I prescribe an analgesic or anti-emetic stat, I don't mean one or two hours later. Have you ever tried to get cough medicine, an injectable tranquilizer, analgesic or sedative at three o'clock in the morning?

Take time to look at the nurse's notes and see what time a drug was given in relation to the time it was ordered. I don't agree with borrowing a drug from one patient to give to another. I would much prefer a supply of cough medicines, analgesics, tetanus toxoid, and tranquilizers, available for use, regardless of the hour. The consultant pharmacist can check these supplies weekly and replace them when necessary. This is all within the limits of the law, and it is not difficult to accomplish, and certainly it is much more convenient.

The attending physician should be aware of all seriously ill patients, and review their charts. He should review all charts of *Medicare* admissions to see if they have adequate admission information, orders, and a planned program of therapy. He should also help prepare the utilization review plan when not done by some outside agency. He should be present at the review committee meetings. He should review prior to the utilization

review meeting all patients to be reviewed.

I might add that utilization review will ultimately involve not only *Medicare* patients but, must be applied to all recipients of Public Law *89-97*, which I believe would include Title 19 patients, those receiving benefits under the medicaid program.

Other responsibilities of the medical director include training of the nurses in the use of specialized equipment, such as intermittent positive pressure suction and even pacemakers which might be implants in patients, then transferred to the nursing home.

He should train the staff in emergency procedures. He should give special lectures to the staff on particular care problems.

He might develop a transfer form or referral form for use at the nursing home.

He should constantly evaluate the progress of patient care and improve where deficient. He should be known to, and have a direct line of communication with, the hospitals with which he has a transfer agreement, and with all homes in the area.

He should be familiar with the services available in the community, either through the Health Department or the voluntary agencies. He should be familiar with the State and Federal legislation as it pertains to the nursing home.

He should develop and carry out employee health programs.

What has been said pertains to extended care facilities and skilled nursing homes, but there is very little that could not easily apply to personal care homes. It is all good medicine, and anything less could be detrimental to patient care. It cannot all be accomplished at one time, but can be gradually introduced over a period of time, but hopefully not longer than a year.

We must realize that the interested medical director can accept and understand the new rules, regulations and responsibilities, but it will take a massive physician education program to inform all the practicing physicians in the community, and to have them accept the changes. This will take time, and we must be understanding, but at the same time we must enforce the law and not back down. If we give in now, we give in forever.

Obviously the job description for a medical director is more extensive than before. He will be required to spend more time at the home performing services not directly related to a patient's care and for which he cannot charge any particular patient. Therefore, I believe the medical director should be compensated for his services, and this could easily be accomplished on the basis of either a consultant's fee or included in the cost of patient care. To expect a physician to be this active, and assume so much responsibility in a nursing home without suitable compensation, would be foolish. We would end up where we started, and all I have said would have been said in vain, and I hope that this is not the case.

Drug Policy And Regulations

Darryl D. Zellers, R Ph

The establishment, maintenance and operation of nursing homes is regulated in all 50 states. The majority of the states vest the regulatory power in the State Health Department which is the case here in Maryland. Some few states vest the power in the State Welfare Department. The laws and rules and regulations themselves range from stringent to loose.

The importance of medication to the chronically ill and aged is obvious; unfortunately, the need for providing adequate pharmaceutical service in the past has not been apparent. State laws and rules and regulations governing nursing homes have been, in the past and still are in many states, generally vague about the handling of pharmaceuticals.

Recently, there has been considerable interest on the part of nursing home licensure agencies in drug control standards. Many states have revised their standards to provide for more effective control of pharmaceuticals.

The Maryland State Department of Health has established new minimum requirements which were adopted last October and became effective January 1 of this year.

Section 18 of regulation 43G02 governing nursing homes, extended care facilities, long term care, and personal care homes, deals with drug handling. This document far exceeds any other states' laws and regulations, regarding pharmaceutical services in nursing homes and extended care facilities, of which I am aware.

With the passage of the *Medicare* Program the Federal Government also expressed its concern for pharmaceutical services in nursing homes. This is evidenced by the "Conditions of Participation for Extended Care Facilities," section 3 titled "Patient Care Policies" and section 8, titled "Pharmaceutical Services."

Since section 8 of the Conditions of Participation for pharmaceutical services in an Extended Care Facility and the Minimum Requirements by the Maryland State Board of Health and Mental Hygiene are very similar in content, my presentation will cover, in general, both sets of regulations. I will also cover briefly the mention of pharmacy service in section 3 of the "conditions," which concerns the formation of a Pharmacy and Therapeutics Committee.

As you noticed on the program my presentation was listed as "Drug Policy and Regulations." Since all of you can read at your leisure the two documents I have mentioned previously I would like to take this opportunity to tell you what is behind these regulations; why they were made; and what they will mean to the nursing home. You should know what pharmacists can and should do for the operation of an Extended Care Facility and in turn why he is essential and not merely "a necessity" to conform with the regulations and Conditions of Participation.

Poor drug handling in nursing homes and small hospitals has been apparent to many pharmacy leaders over the past few years. This had lead to various studies in several nursing homes across the country. These studies and other observations have revealed that practically none of these institutions employ pharmacists. Pharmaceutical services in such institutions are either non-existent or leave much to be desired.

These studies did reveal that although most of the nursing homes were receiving some or all of their drugs from community pharmacists, very few of these pharmacists made routine visits to the nursing homes. They simply delivered the prescriptions the same way as they would to the home of a customer.

Some institutions have a regular drug room under the supervision of a nurse in which they keep supplies of more commonly used legend drugs. Most of these institutions do not even seek the advice of a pharmacist. This is in full violation of federal laws concerning legend drugs.

Briefly, some of the observations made in these studies were:

1. Medications were transferred from stock bottles into individual containers for patient use by non-pharmacists.
2. Improperly labeled drug containers were evident, including such things as handwritten data on tape or paper gum labels.
3. Excessive supplies of drugs resulting in cluttering and wasting of valuable storage space.
4. Excessive supplies of old drugs no longer reliable as to stability and efficacy.
5. External preparations kept together with internal preparations. In many cases they were not even marked "for external use."
6. All employees had access to locked drug cabinets or they were not locked at all.

Administrative deficiencies found were:

1. Lack of automatic "stop orders" on drugs.
2. Lack of proper storage for narcotics and adequate records of use.
3. Lack of separate refrigerator or separate container for drugs.
4. Delays in obtaining refills of a medication for a patient.
5. Lack of an emergency drug box.
6. Lack of written policies for handling drugs.
7. Lack of drug reference books.

Although these incidents were observed in studies scattered throughout the country in a small number of institutions, it is indicative of the pharmaceutical services in the majority of nursing homes. This is not to say that all of them are guilty of all of these deficiencies.

One thing that must be stated here is that nursing homes are not the only offenders. Approximately 45% of the hospitals in this country are still without the services of a pharmacist. It is true, however, that many of these are small and cannot have a full-time pharmacist and are, therefore, in the same position as many nursing homes.

I must also admit that the pharmaceutical services in many larger hospitals with established pharmacy departments still leave a lot to be desired. However, our American Society of Hospital Pharmacists (which incidentally is only 25 years old showing how new the area of institutional pharmacy is), through the leaders in hospital pharmacy, is taking great steps to correct these problems by an excellent educational program.

These brief observations of what has been happening are reasons for the new regulations for pharmaceutical services in nursing homes and small hospitals, and for the Conditions of Participation in an Extended Care Facility.

"The administrator of a nursing home has a moral and legal responsibility to provide optimum medical care for the residents of the home. In discharging this responsibility he must provide a scope of service that is commensurate with established legal and medical standards. Although the administrator is responsible for total operations, he cannot discharge his responsibility for pharmacy service except through the assistance of a licensed pharmacist. The pharmacist is the only individual who is qualified by law and by training to perform the pharmacy functions that are necessary for an adequate and safe health care program."*

"All nursing homes should be cognizant of the contributions made by a sound and organized pharmaceutical service for improved patient care and treatment."*

At this point it is important that we differentiate between the three phases involved in use of medications. These are prescribing, dispensing and administering. These are defined indirectly in both sets of regulations that we are concerned with.

Prescribing, which is the selection of a particular remedy to alleviate a particular symptom or group of symptoms, is held to be the prerogative of physicians and dentists in most states. It is therefore important that the practitioner provide a written order for any medication he wishes to be administered. Provisions, however, should be established for emergency orders given by other means.

The act of dispensing in most states is considered the sole prerogative of the pharmacist or physician. The principal duties involved in the act of dispensing is interpreting the physician's order, selecting the medication, transferring from an original container to an individual container for a specific patient and labeling that container in a proper format. This format is specific in the regulations in that it must contain the patient's full name, the name of the drug, potency, directions for use, date, name of physician, and expiration date if applicable. The Conditions for Participation recommends that the manufacturer and lot number also appear.

Administering the medication includes, besides actually giving the medication, recording the act, observing any reactions, and reporting medication errors. This is to be performed by the nurse on duty.

The method by which the necessary pharmaceutical service in the nursing home is accomplished may vary depending upon the size, organization, and policy and procedures of the institution. It will fall into one of the following categories:

1. No pharmacy in the home.
   (a) Working agreement with a community pharmacist.
   (b) Serviced by a pharmacist of a hospital.
2. Licensed Pharmacy in the home.
   (a) Pharmacist on duty continuously.
   (b) Pharmacist on duty at intervals.

This brings us to the point of what services a pharmacist can provide for a nursing home.

Whether a nursing home can support its own pharmacy with one or more full-time pharmacists, or with a part-time pharmacist, or if it only has a consultant who comes in on a regular schedule is immaterial. There are many functions of pharmacy service that can be accomplished.

First of all, he, along with some of the physicians, should organize a Pharmacy and Therapeutics Committee. This is spelled out in section 3 of the Conditions of Participation for an Extended Care Facility. It is this commitee's duty to develop policies and procedures that will regulate the

* "Pharmaceutical Services in the Nursing Home."

pharmaceutical service in the institution. It should also compile a drug list or a formulary listing the drugs to be used in the institution.

The main day to day function of the pharmacist of course would be to dispense drugs, properly label them, and make them available to the appropriate licensed nursing personnel. Wherever possible he should dispense the drugs directly from the prescriber's order or a direct copy.

The pharmacist may also prepare a medicine ticket that the nurse uses in administering medications, and possibly even a medication administration record that she uses to record each dose administered. In carrying out these functions the pharmacist may also keep a running drug profile on each patient which gives a total picture of the drugs given to that patient and also serves as record to check against, for possible incompatibilities, when new orders are written.

The pharmacist will make routine visits to nursing units to check medication cabinets for out-dated drugs, to be certain that heat sensitive drugs are refrigerated and that all drugs are still properly labeled and in satisfactory condition. It is his duty to destroy drugs no longer in use or for some reason are not fit to be administered.

The pharmacist will provide an adequate control system for drugs that, by law, need extra controls such as narcotics, barbiturates and the new group of drugs covered by the *HR-2 Bill* including amphetamines, hypnotics, and certain psychosomatic drugs.

If the institution has a pharmacy, the pharmacist may also be able to produce some of the drugs and related products such as antiseptic washes, soaps, etc., in the pharmacy.

There are other areas throughout the institution, in which the pharmacist, due to his wide background, can be utilized in an advisory capacity.

As I mentioned previously the average community pharmacist lacks knowledge and experience in providing the services I have mentioned. Institutional pharmacy over the last several years has become a somewhat specialized area of pharmacy with rapid development of additional services. Most pharmacy schools have only recently added courses in this area to their curriculum.

Since there is such a great number of Extended Care Facilities needing pharmacists and the present shortage of trained and experienced institutional pharmacists, the National Pharmaceutical Council has provided a grant to the American Society of Hospital Pharmacists to establish a training program to orient community pharmacists to institutional pharmacy. It is in the process of establishing a training program under this grant in Maryland that will be getting under way within the next few weeks. In this program we take the pharmacist into institutions and train him in an institutional atmosphere. I am confident that we will succeed in providing a sufficient number of pharmacists to provide excellent pharmacy programs for all of the Nursing Homes and Extended Care Facilities.

There is one other area I want to mention briefly and that is economics. I think everyone involved with nursing homes should not be too hasty in judging what this service will cost. With an actual feasibility study, many administrators would be surprised at the cost considering the money that the pharmacist could save in purchasing, in a limited amount of manufacturing, and in other areas in the institution. The results of such a study will determine whether the home needs a full-time or a part-time pharmacist or just a consulting pharmacist.

I hope that from what I have related to you here today about pharmacists, it can be seen that he can be an asset to any individual or organization using drugs. Every nursing home should avail itself of the service and skills of a pharmacist on no less than a consulting basis.

Interplay of Hospitals and Extended Care Facilities

J. Roy Guyther, MD

Those who wrote the Social Security Amendments that became PL89-97, known as *Medicare,* recognized that some type facility to serve as a Half-Way-House for hospitalized patients before being discharged to their homes would accomplish two important purposes. By extending the care that has been provided to a patient in the acute hospital to another facility, hospital beds could be emptied faster, and less costly care could be provided the patient during his or her convalescence. To accomplish this aim the Extended Care Facility was conceived. I do not believe that the framers of the law expected a very high percentage of nursing homes to modify their institutions to the necessary extent in meeting the conditions for participation as an Extended Care Facility. I believe the planners envisioned a new type facility, and in addition expected hospitals to establish separate divisions to meet a significant portion of the need. At any rate, the conditions for participation as an Extended Care Facility were rather stiff. The purposes of the regulations are to upgrade nursing care in the qualifying facilities, and to provide more comprehensive services.

In order to receive payments for extended care, under *Medicare,* a facility must have the following:

1. A transfer agreement in effect with one or more hospitals.
2. Be engaged primarily in providing skilled nursing care and related or rehabilitative services.
3. Have policies developed by a group of professional persons, including one or more physicians.
4. Have a physician or registered nurse responsible for execution of policies.
5. Guarantee that the health care of every person admitted be under the supervision of a physician, and that a physician be available for emergency medical care.
6. Maintain clinical records on all patients.
7. Provide 24 hour nursing service with at least one registered professional nurse employed full time.
8. Provide a method for dispensing and administering drugs.
9. Have a functioning utilization review plan.
10. Meet such other conditions relating to health and safety as the Secretary of Health, Education, and Welfare may find necessary.

All this must be in addition to meeting the licensing standards of the state in which the facility is located.

In order for a patient to qualify to have costs paid by *Medicare,* he must have been an inpatient of a hospital for at least 3 consecutive days and to have been transferred to the Extended Care Facility within 14 days.

In order for Extended Care to be efficiently given to a post-hospitalized patient certain things are necessary. Some sort of an agreement between the hospital which first treats the patient, and the facility which is to provide the after care needed. This agreement, referred to as *"transfer agreement"* may be as simple as Figure 1.

Model transfer agreement between

_____
Name of Hospital

and

_____
Name of Extended Care Facility

To facilitate continuity of care and the timely transfer of patients and records between the hospital and the extended care facility, the parties named above agree as follows:

1. When a patient's need for transfer from one of the above institutions to the other has been determined by the patient's physician, the institution to which transfer is to be made agrees to admit the patient as promptly as possible, provide customary admission requirements are met.
2. The transferring institution will send with each patient at the time of transfer, or in the case of an emergency, as promptly as possible, the completed transfer and referral forms mutually agreed upon to provide the medical and administrative information necessary to determine the appropriateness of the placement and to enable continuing care to the patient. The transfer and referral forms will include such information as current medical findings, diagnosis, rehabilitation potential, a brief summary of the course of treatment followed in the transferring institution, nursing and dietary informaton, ambulation status, and pertinent administrative and social information.
3. The transferring institution will be responsible for the transfer or other appropriate disposition of personal effects, particularly money and valuables, and information related to these items.
4. The transferring institution will be responsible for effectng the transfer of the patient, including arranging for appropriate and safe transportation and care of the patient during the transfer.
5. This agreement shall be in effect to and including the 31st day of December, 1967, provided it may be terminated by either facility upon —— days written notice and shall be automatically terminated should either facility fail to maintain its license or certification.

Signed:

_____	_____
(Name of Extended Care Facility)	Administrator
_____	_____
(Name of Hospital)	Administrator

It should at least provide for two conditions: First, that transfer in either direction from a hospital to an Extended Care Facility or vice versa can be carried out when it is thought to be appropriate by the attending physician. Second, that appropriate information about individual patients is forwarded at the time of transfer to provide continuity of care or to assist in determining whether patients can be cared for adequately in some other way in the community. This has not always been the case in the past. I am told that at times a patient arrives at a nursing home with no information other than a name. The agreements should also contain provisions making available the diagnostic and therapeutic services on an outpatient basis as ordered by the attending physician, to a reasonable extent under the circumstances. This is essential to avoid costly duplication of services. Charges for services performed by either facility should be collected by the institution rendering such services, whether directly from the patient, third party payor, or other sources normally billed by the institution; neither facility shall have any liability to the other for such charges.

Difficulties will be encountered. One difficulty that can be experienced is transportation of the patient. Even where the two institutions are in close proximity it is usually necessary to provide ambulance transportation. For a *Medicare* patient, fees for transportation are covered, but the mechanism for collection of this fee is vague. If the patient is indigent, more complications arise. The State Department of Health is attempting to provide a solution to this problem now.

A second problem that may occur is in the event of transfer back to the hospital of a patient whose condition becomes temporarily worse. There may be a feature in the transfer agreement providing that the Extended Care Facility shall retain—for a reasonable period of time the bed of a patient who has been transferred to the hospital, and shall accept him back upon discharge from the hospital. How far the obligation of the Extended Care Facility extends in this direction is uncertain, especially since the Social Security Administration advises that no *Medicare* payment will be made for unused bed space for the transferred patient.

A third problem arises because of the fact that the attending physician tends not to display the same level of interest in a patient in the Extended Care Facility as in the acute hospital. He is naturally reluctant to travel to the other institution, even though it may be only across the street. Therefore there is some unconscious resistance to transferring patients or recommending transfer as soon as it can be considered. The patient recognizes that he does not get the same attention in the Extended Care Facility, and he too develops resistance or dissatisfaction in the new surroundings.

We have touched briefly on the main features of interplay between hospitals and Extended Care Facilities. The key to success in this inter relationship is good communication between the two. The attending physician must keep the communication lines open. Problem areas inevitably develop, but they are not insoluble.

Utilization Review Committees

George Sharpe, MD.

When Congress wrote Title 18, it created a new institution, a dynamic type of institution, to exist possibly in every community in the country. This dynamic institution was to be called the Extended Care Facility as opposed to the so-called traditional nursing home.

However, the subject is apropos here because the intent of Congress was to provide an uplift in the medical services to patients and, as already noted, to relieve bed shortages that existed in acute hospital care.

There were many basic requirements for the establishment of an Extended Care Facility, but it was hoped much of the uplift in standards would come from review committees. This would also involve nursing homes caring for welfare patients as

well as others.

One of the keynotes of requirement for the upgrading of medical care was the establishment of utilization review committees. This utilization review committee concept is not new in hospitals over the country, but it is certainly new as far as institutions throughout the community, aside from hospitals, are concerned.

This meant of course that the burden of responsibility was going to fall into the hands of the physician. This is noted throughout here and I don't like to think of it personally as a burden I think of it more as a challenge. It really does give us a new instrument for the care of patients; however, at the same time it does give us a great deal of responsibility for providing for this care under the new laws that are going to be with us, and those who are going to practice medicine, for a long time to come.

It is to be noted that Congress actually in discussing all this wanted to provide flexibility in order to insure cooperation of MDs, hospitals, as well as Nursing Homes, Care Homes and others, health departments, county health departments, state health departments, and above all physicians; and flexibility is in the law at all stages, if one really looks at it that way. That is why we have some of the confusion, because of the flexibility that is present.

From the standpoint of the new facility that I mentioned, there are certain differences from a general hospital. First of all, we have to overcome old habits. We must change habits of patients and families, as well as their expectations of the new facilities.

In a hospital there is an intimacy of the staff we don't get when we talk about an Extended care Facility, as in most cases there is no large staff.

Another important point Congress noted was that traditionally patients selected nursing homes or Extended Care Facilities, or perhaps the social worker did, but in this situation it is going to be the physicians. The law provides that entrance to an Extended Care Facility is upon certification by the physician, and 14 days thereafter recertification by the attending physician.

The Extended Care Facility then in return is to provide high quality care, and this is going to have to take place, with a utilization review committee overseeing proper use of the facilities.

Also recognized by Congress, and by others, is that these facilities would have an educational value if properly used. It was also intended that the use of Extended Care Facilities should be encouraged so that a patient could partake of rehabilitative services as well as skilled nursing care and at the same time relieve the hospital bed situation.

There is one other point. This has not been mentioned today, but it is a key point that we must not forget. It is a duty of the Extended Care Facility to arrange for the future care of the patient. This is in the law. This was an intent of Congress. You now have a dynamic situation, and it is in the hands of the physician, as so ably pointed out by the speaker from St. Marys County, to provide for the flow of patients from hospital to Extended Care Facility, back to his own home or to a skilled nursing home or personal care type of home.

This flow is in the control of the utilization review committee which has certain responsibilities; to see that proper records are kept, to see that sampling of admissions is to take place to insure efficiency of operation, and so forth. It is also responsible for dissemination of the reports, and examination of every case of extended duration in an Extended Care Facility.

This is a term that is another key point, "Extended care duration." In our situation it was defined as 30 days. I have a hunch this is going to be accepted pretty generally all over the country or certainly in Maryland.

This means that the personal physician certifies the patient, then recertifies the patient after 14 days for a total of 44 days. Remember now on the second certification he must include a plan of operation as to what is going to happen to that patient afterwards.

Therefore, if we have an extended stay duration of 30 days, every one of the patients he certifies is going to be subject to a review. However, the law does provide in all cases where the review committee disagrees with the personal physician, this personal physician shall be consulted. It may be that he has something to add that will change their opinion. But his viewpoints are paramount.

At any rate, it is in the hands of a doctor, not a social worker, as to how much care this patient is going to need. He can control this patient's care in

the Extended Facility for 44 days. He may have to explain it, that is possible, but highly unlikely if he uses his own judment properly.

The utilization review committee under the law can be made up from the staff of the Extended Care Facility, including two or more MDs or other professional people, including a physical therapist, a social worker or—and this is important—by a group outside the institution which is similarly composed and which is established by the local medical society—this is specifically mentioned in the law—by the hospital, or hospitals of a community.

If none of these two or three, depending on how you want to look at it, groups or sources is used, then the Secretary of *HEW* can suggest or use another method that would be approved by *HEW* for the purpose of providing utilization review.

The utilization review committee must review, and appraise medical care that takes place within the facility. Remember, that this can be done by two different groups. In other words, one group could be so-called medical standards group—this is a term we developed—and a utilization review committee that would sample by various means all the admissions to the facility. The other function is that the utilization review committee has to pass each individual case of extended stay, and determine the duration.

The physicians who are involved can have no financial interest, or I should say at least one of those who is involved in the review shall have none, as provided by law. However, on local levels, this may be varied.

The review sample has to take into consideration the duration of stay, professional service, including drugs, use of them, and also whether the available facilities are properly being used, analysis of patterns of care and maintenance of high quality.

The staff of the review facility must cooperate with the physicians to improve the efficiency and to help place patients afterwards.

We in Montgomery County have devised an idea, and we were able to get a grant we have been holding in effect for about six weeks. We have used the society as a whole as a review committee. There are some 600 physicians in the area which has a population of half a million.

We have a coordinating committee. Under this we have a utilization review committee that has established a few criteria that each man who goes out has to use—and I won't go into those now. Then he uses his own medical judgment to pass on the patient, always then to consult with the attending physician. These are things we have developed.

I might say that these physicians who are on review are paid a fee of $25 an hour for their review. It takes an average of four to eight minutes to review a case, and they will do maybe fifteen or twenty cases. It has been very interesting.

The other thing we are doing is developing a fixed committee composed of various specialties concerning themselves with standards, and who will go to the facilities, and help them to develop their standards.

I would like to say in conclusion that we took this as a challenge instead of a burden, and we found it very interesting, and really exciting. This goes to all age groups, those who have been practicing for twenty years or more, and those who are just starting practice and who are going to have to live with it for the next twenty or thirty years.

Medical Records

Edyth H. Schoenrich, MD

Let me say how gratifying it is to see that so many physicians associated with nursing homes have been willing to take this day from their busy schedules and spend it at this meeting. The field in which we are all working is not one that in the past had either status or glamor, and yet it is a field of medicine which is becoming increasingly important. Those physicians who have grappled with the complex problems of chronically ill and aging persons recognize that the successful man-

agement of these cases demands the clinical task at its finest.

Though the topic of my discussion is medical records, I intend to talk about *clinical* records. The terms "medical records" imply restriction of the topic to physicians' notes. In truth, the discussion must be much broader and include not only physicians' notes, but also nursing notes, order sheets, medication records, and all other notations of every professional group concerned with diagnosis and treatment of cases in nursing homes.

Why need we be concerned about clinical records? Though many obvious reasons come to mind, I wish to make four major points.

First of all, in the management of the problems of chronically ill and aging persons, quality of care is unquestionably related to continuity of care. This continuity of care must be maintained as a patient moves from one institution to another. When there is a flow of patients from one institution to another, there must also automatically be a flow of appropriate information. Dr. Sharpe and other speakers have touched upon this point earlier today.

I have worked in chronic disease hospitals long enough, and have observed the nursing home situation closely enough, to have been all too frequently infuriated by the way patients are transferred from one location to another without adequate records. Though I could cite the details of individual cases, I know that all of you who have worked in nursing homes have received patients undiagnosed and too unstable medically to be cared for in your facilities—yet they arrive without adequate records.

As a second point, I am sure you will all agree that not only must there be a flow of information when patients move from one institution to another, but also when the responsibility for a patient's care moves from one physician to another, even within one institutional setting. It has been brought out several times by other speakers today that, though patients may have personal physicians, these personal physicians are not always available for visits to nursing homes when they are needed. In such circumstances it is very often the *Principal Physician* or the *Medical Director* of the nursing home who becomes responsible. It is highly probable that each one of you has had the uncomfortable experience of intervening in the care of another physician's patient without the benefit of adequate clinical records.

A third reason for concern about clinical records in nursing homes revolves around legal implications. Here I am concerned not only about the welfare of the patient, but also about the protection of the management and staff of the nursing home. Many chronically ill and aging persons are frail, severely handicapped, confused, and often seem accident-prone. They tend to fall, suffer broken hips, and receive lacerations. These facts mean that the persons and institutions caring for these patients are exceptionally vulnerable. So, for the protection of the staff as well as the patient, meticulous documentation of the diagnoses, special limitations, treatments, and untoward incidents is essential.

As a fourth point about the value of excellent clinical records, one becomes involved in the increasingly important field of medical audits. I recognize this is a very delicate question at the present time, but it is no longer possible to deny the fact that quality of care is now becoming a concern of more than physicians and related health personnel.

Let me digress to discuss briefly some of my own personal feelings about the question of medical audits. Surely most of us would agree that it is a solid American tradition that, at some level, the public has a right to inquire about how effectively public funds are used. For example, this right has long been recognized when public funds are used for highways or building construction. Now that more and more health services are being funded by broad-based tax resources, it is natural extension of the American pattern that there be a review of health programs. We all realize this is the principle behind the concept of utilization review which has had much discussion today.

I don't think the concept of the medical audit has to be frightening to the health professions. I also do not think that it has to be something imposed from above. How much better it would be if other medical societies would follow the example of one of the county medical societies in Maryland that has become deeply involved in organizing and supervising utilization review.

Also, one of the physicians at this meeting has recently been working with the Social Security Administration to establish guidelines—not absolute rules but guidelines—for what is a "meaningful visit" by a physician to a patient in a nursing

home or hospital. Even though this is a controversial matter, I feel that sometimes guidelines can be of positive benefit in that they describe, at least in general terms, what is and what is not expected in a given situation.

What actually are the regulations concerned with the clinical records in nursing homes? These are spelled out on pages 492 and 493 of the *Rules and Regulations for Long Term Nursing Homes* in the State of Maryland. I am sure most of you are familiar with these. These regulations concern items which I do not think any physician could possibly find objectionable if he is seriously concerned about the quality of care given to long term patients.

For example, it is required that there be accurate identification of the patient, including his age, where he came from, his identifying code numbers, and whom to contact in case of emergency. There also should be recorded the information which accompanied the patient when he arrived at the long term Care Facility. Both Dr. Sharpe and Dr. Guyther have discussed this. There should also be a complete work-up by the physician who will be caring for the patient in the nursing home. Surely there would be general agreement that the initial history and physical examination on each admitted patient should include all the significant medical events and a complete physical examination.

A few words are necessary regarding progress notes. All of us who have been active in providing direct patient care understand that a physician who has cared for a patient for a long time does not always record in progress notes every nuance of the problem and treatment. Those of you who work in rather small institutions may be able to know all the essential details of the complex problems of each of the patients under your care. However, we have to face the fact that in many of the larger nursing homes, where there may be as many as 100 or 150 patients supported by public funds, and in which the burden of care for most of these patients falls upon the *Principal Physician* of the home, good clinical records are the only practical channel through which the physician is able to provide care of appropriate quality.

In relation to this, I want to expand briefly the remarks made this morning about the survey of nursing home records that was done in Baltimore City this past summer. As you recall, the records of about 300 welfare recipients in nursing homes were examined. In 14% of these cases there was no note recorded by any physician at the time of admission. In 44% of the cases, the admission notes by the physician were less than 31 words. I want to point out that this is approximately three typewritten lines. In addition, there were many serious omissions, such as no recording whatever of a blood pressure reading even though the diagnosis of heart disease or hypertension was listed.

In what ways can physicians contribute to the improvement of clinical records in nursing homes? Obviously, they can see that their own data are recorded in a clear thorough manner, and they can insist that the records in the homes in which they work include dated and signed nursing notes, medication and treatment records, consultation notes, and laboratory reports.

In addition, physicians can assist the nursing home administrators to develop or to choose appropriate forms for recording clinical information. The very excellent book, *Concepts in Nursing Home Administration,* by Harold Baumgartner contains a chapter on medical records with examples of simple forms. A number of publishing houses prepare such forms which you might recommend adopting, or which you might wish to alter to meet specific needs.

I wish to say one final word. I have a deep conviction that the most important single influence capable of elevating the quality of care in a nursing home is the physician who goes in and out of that home and the professional conscience which guides him.

(*Continued on page* 58)

Discussions

Dr. Levitsky: We come now to the end of the formal presentation. The floor is open to all and we hope some of you who have not told us of your experiences in nursing homes will speak to us so we can all be aware of the many problems existing and have other than a parochial idea of what are nursing home problems.

Dr. Campbell: We have a convalescent home, with facilities for 137 patients. My chief concern is with the attitude of some hospitals, toward medical care patients, not particularly *Medicare* alone. Sometimes a patient is in dire need of hospitalization, the hospital will be called, and the situation is presented to the individual who answers, but it seems they have no concern at all about these people.

They do not want to accept them. On one occasion I had a man who was quite ill, in fact he was unconscious at the time. I called the hospital and identified myself, relating the situation of the patient. The question was, "Doctor, do you belong to this hospital staff?"

I said, "No, I don't. This is a *medical care* patient who is sick." The patient was refused as I did not belong to that hospital's staff.

This actually happened. Possibly other doctors have had that experience.

The next point is the ambulance. The ambulance people have a rule that states they must take the patient to the nearest hospital. This does not pertain to everyone. An accident occurred in which a woman's legs were crushed. It was about three minutes ride from this point to Provident Hospital, yet the ambulance service took the patient all the way to Maryland General.

On another occasion a man was struck just one block from Provident Hospital, yet the ambulance took him to Maryland General. This rule is not enforced, it is just for certain situations.

On another occasion the ambulance driver actually came to the nursing home where the patient was unconscious, and refused to take the patient because the woman was on the second floor. The nurse called me and by the time I got to the telephone they had driven away and I had to use some pressure to get them to return and take the patient to the hospital.

Later I called the person in charge of the program, and he told me that one of the ambulance men had developed a hernia by helping carry a patient. My reply was that if he were a doctor practicing medicine, would he object to going to a person with pneumonia or tuberculosis because he was afraid he might get the disease.

His reply was that those were the rules. I did not go to the newspapers, but called somebody else, and in half an hour a news reporter called me to find out what had happened. The next morning I received a call from the ambulance service that I would not have any more trouble. They did come for the patient, but the man died that night.

On another occasion I called an ambulance; it arrived; the man was on the second floor, and they refused to get him. While they were haggling about it, the nurse, who weighs 155 pounds, brought the man down in her arms to the ambulance driver.

While the ambulance personnel have done some good turns for us as physicians, I can't understand why an attendant would refuse to get a patient because he or she is not on the first floor.

Those are some of the problems we have. The man who died the next day might have died in any event, but they refused him, and we have to use strong measures sometimes to get them to take certain patients to hospitals.

Dr. Benack: Today we have placed pressure upon the physicians and their responsibility. The State has given us regulations which we are expected to abide by. I would like to place a little pressure upon the State.

We can't really do a thing, to be perfectly honest, until the classification of nursing homes according to standards tell us where we can ship patients when they are in need of this care. One of the confusing problems is the lack of clarification as to what type of facility is an Extended Care Facility, which is a nursing home, which is custodial care. They are all important, but unless we have homes so designated, we cannot do anything, because, even as the utilization review committee is expected to do, it is supposed to recommend the care beyond the Extended Care Facility, yet we do not know what is beyond this facility as nobody has so designated the homes.

I think it is imperative that the State Health Department designate these facilities. It is eight months since the law has been in operation, and still we hear only of the Extended Care Facility. I don't know where the other ones are.

*Mr. Fritz: We publish a directory at least once a year. This will list all types of homes by categories. Those nursing homes that have been certified as Extended Care Facilities will have an asterisk with a footnote to that effect.

The others listed will be long-term nursing care, and the personal care homes, of which there are very few, and these will be listed separately. As soon as they are collated, they will be made available to all the nursing homes, the *principal physicians* and other agencies.

Dr. Davens: But it really is not that simple, and I do not think the clarification will come for several years.

Dr. Sharpe and Dr. Guyther explained very clearly in their talks about the new concept of the Extended Care Facility which Congress had in mind. If you go back and read the Congressional report on Public Law 89-97, you will see very clearly, if one needs convincing, that Congress did not have 100 days of nursing home care in mind with respect to Title 18.

They did have, as you explained it very clearly, Dr. Sharpe, a new concept of *convalescent* care facility, and it was pursuant to that new concept of *convalescent* care for acutely ill patients that the guidelines of the Social Security Administration were developed.

However, the Welfare Administration, in connection with their interest in upgrading the quality of nursing home care, or long-term custodial nursing home care if you will, looked around for standards that it felt would be appropriate national standards, to require with respect to matching medical assistance programs, such as our medical assistance program, and *Mrs. Winston decreed that all nursing homes in medical assistance meet those standards.

In other words, these standards were developed for a different purpose, but it was thought that all nursing homes should meet those same standards, even though it were for a different purpose.

This is the problem that Dr. Peeples referred to this morning when he said that he was hoping we would get some time to work out a period of time where we could have the two grades; but I think the national intent is that all nursing homes would meet those standards.

Dr. Sharpe: I would like to follow through here on a slightly transcendental point, but one brought up which is very important. This is something where I think principal physicians could take a very firm stand right now.

In the Washington area, some of these Extended Care Facilities and some of the nursing homes, are advertising in a way that implies that all this is just coming to you. This puts a tremendous burden on the physician, because the advertising states—and I will quote it almost verbatim: "Remember, you can save thousands of dollars in our nursing home, which has been approved for *Medicare,* so bring your loved ones here, and they will be properly taken care of, and under the certification you will save."

This is tremendous "come-on" advertising, and this is something everyone here who is a principal physician could stop.

Another point, it is not just the nursing homes but it is the articles in the newspapers. If one reads the articles written on the law, one sees that they do not really spell out the fact that this is a new concept of nursing home care; they merely say you are entitled to a hundred days.

Here I am talking about the lay writers. Statements do not come out exactly the way they are supposed to.

If one reads the Washington papers one finds that Extended Care Facilities have been publi-

*Mr. H. Fritz, Chief of Division Medical Facilities, Development of the Maryland State Health Departhent.

*Mrs. Ellen Winston, Commissioner, U.S. Department of Education and Welfare.

cized and will be publicized more and more, because the Montgomery County Medical Society is taking a stand, and taking the lead.

This is the reason I am here. This is one of the things I was hoping we could get across here in this group, because you have a tremendous amount of power in your hands right now.

*Dr. Vollmer: Conversely the other thing is happening too, that is, homes primarily for custodial care are now being chastised by the public as second rate homes. For instance, the Edgewood is a custodial home, and patients are saying, "I don't want to go there because it is not accredited," so it is working in reverse too.

†Dr. Sachs: I wanted to say that as I have listened through today, I think it would be helpful if you could realize that under the Social Security Amendments, Title 18 and Title 19 are as different as if they were two separate laws. The State Health Department under the Medical Assistance Program, part of which is funded by Title 19, is essentially carrying out Title 19.

Title 18 is open-ended, and payments are different. There are standards set, and there is not too much intervention by the State Health Department, with the exception of the approval or recommendation for certification of participating hospitals, Extended Care Facilities and home health agencies.

The confusion that comes in is that two-thirds of our Maryland medical assistance program is funded by the State Legislature budget funds, and we are all aware of the tremendous discrepancies regarding what we have to put into the program. This is why you find very contradictory amounts of services that can be covered.

Oddly enough, Titles 18 and 19 cannot exist separately because where there are deductible and coinsurance factors, if the person sixty-five years and over is also eligible as a medical indigent to be covered by the Title 19 funds, that program must pick it out.

So it becomes utterly ridiculous to have, as you mentioned with a custodial home, somebody getting the feeling it is second rate. We can not have two levels of quality. We can not have the extent of care different, and we can not expect physicians or nurses or other people, to handle first rate citizens and second rate citizens.

Primarily, if you believe in the care of the chronically ill or the aged, you know that it is a continuous spectrum of care, and peo,le can not only move from an Extended Care Facility to a skilled nursing home, to perhaps a foster home, but may have to go back to an acute general hospital, and this I think has to keep rotating all the time.

I think my primary job is to keep reviewing this material, and not get confused. Really if there are any major confusions which aren't spelled out in the beautiful jargon that creeps into regulations and laws, I am sure if you wrote Dr. Davens, he would see that one of us who are working all the time in this field clears it up.

Dr. Levitsky: In a short sort of summary, I find I have very little to say because everybody who spoke before covered the issues so well. In summary though I think it is certainly gratifying to find that so many people did take the time to come here and to be with us and to speak. I am even more amazed by the awareness of the problem and the almost universal problem that exists, that there is a certain desire to learn what is needed. It all seems to be tempered somewhat by the requirement to be practical and to try to find out what we can do.

I think there is a lot of confusion which comes about because we have difficulty defining words. The words "nursing home" no longer have a valid p'ace in our vocabulary—even though I have been one of the people who have been most consistently using the term.

I think one has to get some sort of educational program going. I think this is certainly one of the roles the Medical Society of this State plays. The responsibility of organized medicine is to help publicize this. The concept has to grow that there is such a thing as a hospital, as different to an Extended Care Facility, and from there to nursing homes, to custodial or chronic Extended Care Facilities (if there are such places), or long-term care facilities.

The education problem is with the people, with the government, with the agencies, and it is with the physicians. Physicians certainly also have to be educated, because they have to realize they no

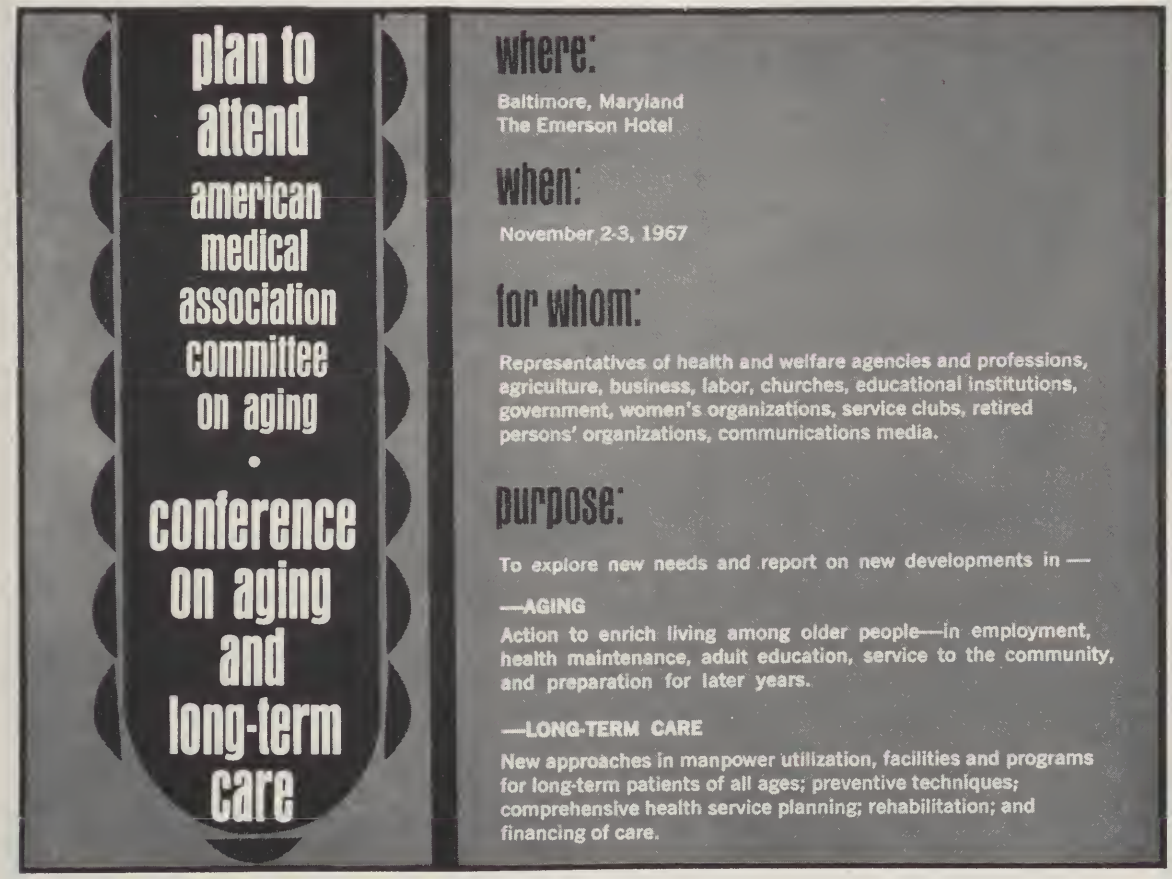
*Frederick J. Vollmer, MD, Edgewood Nursing Home.
†Miriam Sachs, MD, Chief of Division of Medical Care Studies of the Maryland State Health Department.

longer have the luxury of keeping somebody with, say a stroke or heart attack, in an acute hospital bed at $40 or $50 a day. This no longer exists; these people should sometime, very early during their illness, be sent to a lesser staffed unit in the hospital, or to a chronic care facility. If there is no adequate care at home, then they should be sent to a custodial care or old age home. We all know that "old-age-home" has a bad connotation, let's find a new term for it.

It is hard to say where educational process starts, but I think the general public has to understand that it is really a different concept of the practice of medicine.

People have to be made aware they are being sent to the place best for them, for the kind of care they need, just as a pregnant woman goes to the obstetrical ward and not the pediatric ward.

It will take many years before we can do all this. But there are practical considerations as to what we can do now to make whatever we have work better. It is worthwhile to consider upgrading this care, and I think the principal physician has to take an active role.



In Memorium

EUGENE I. BAUMGARTNER, MD, of Oakland, Md., who died of a heart attack on August 7, will be sorely missed by his colleagues throughout Maryland and the entire United States. "Gene" as he was affectionately known by those close to him, was a personable individual and liked by all with whom he came in contact.

Active in medical affairs he had served for many years with the state organization in numerous capacities. Currently, he was acting as a member of the Advisory Committee to the Maryland Medical Assistance Program, the forerunner of which was the Council on Medical Care. He had been the medical profession's representative on this latter group for some 9 years. He had also served as a Vice-President of the Faculty in 1965; as well as on numerous Faculty Committees.

Gene was always present at Faculty meetings and was actively aware of "what was going on." Local physicians contacted him first when they wanted to know what was happening in the medical world.

Since 1962, he had served on the American Medical Association's Council on Scientific Assembly. This Council is charged with the preparation of the AMA's Annual and Clinical scientific programs. In addition, it is responsible for arrangements of the annual Science Fair, which the AMA co-sponsors along with other major professional organizations. This fair was held in Baltimore, Maryland, in 1965, and Gene had considerable to do with its outstanding success at that time. He always served as a judge for this fair as well as for the scientific exhibits at the AMA meetings.

Dr. Baumgartner was also one of the presidents of the Maryland Academy of General Practice and was a founder-member of this state group. He was also active in the American Academy of General Practice. At the time of his death, he was president of the Garrett County Medical Society.

A graduate of the University of Maryland in 1931, he began practice in 1933, and joined the Faculty in 1934. He was one of the fast-disappearing family physicians and firmly epitomized that position. He was a counselor and friend to all of his patients and was selected by the National Institutes of Health to portray himself as such a person in a film that received national distribution. The film portrayed the importance of a family or primary physician and showed the proper manner of handling patients.

An avid follower of the circus and theater, he acted as drama critic for the Garrett County playhouse; and served as ringmaster for the Oakland Rotary club when it sponsored a circus as one of its public service ventures. He was a past-president of the Oakland Rotary club; a Senior Warden of St. Mathews Episcopal Church; a former Deputy Medical Examiner; former Chief of Staff at the Oakland Memorial Hospital; and served on the board of that institution. He also served, at one time, on the Democratic State Central Committee.

Dr. Baumgartner was a native of Oakland having been born there in 1905, graduating from the local high school in 1928. He served his internship at Mercy hospital, Baltimore, following graduation from medical school. He is survived by his wife, Mrs. Helen Baumgartner (nee Tracy).

CURRENT APPROACHES TO THE MANAGEMENT OF PATIENTS WITH MALIGNANT LYMPHOMA

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The malignant lymphomas consist of the conditions, Hodgkin's disease, lymphosarcoma and reticulum cell sarcoma. These diseases tend to afflict young adults and middle-aged individuals at a time when either the hopes of the future are the brightest for the young patients or when the latter group has achieved the middle years of productivity. What can we offer these patients? At a recent conference at the National Institutes of Health, a provocative title was put forth. It states: "Hodgkin's disease, can it be cured?" By the end of the evening, it was suggested that the title should really have been, not can it, but how many.[1]

Thus, I would like to leave with you the feeling of optimism. For some patients with Hodgkin's disease, cures are possible. For many other patients a better symptom-free survival is possible with chemotherapy. Let us now examine some of the reasons why we can be more hopeful.

One of the recent advances in Hodgkin's disease has been the reclassification of the histopathology recently described by Lukes and Butler.[2] In the old classification of Jackson-Parker, the disease was characterized as paragranuloma, granuloma, and sarcoma. Unfortunately 90% of the patients fell in the granuloma group, 5% in each of the other groups, so that it was very hard to define any significant statistical relationship of histology to survival or prognosis, except for 10% of the patients. Lukes and Butler reviewed a large series at the Armed Forces Institute of Pathology and derived a classification based on the lymphocytic and histiocytic population and the degree of fibrosis which was either diffuse or reticular. As the disease progresses the histopathology appears to shift from one of lymphocyte predominance to that of lymphocyte depletion. Those patients presenting with the histiocytic predominance type have shorter survivals and poorer responses to treatment.

Another important finding has been the knowledge that with high dosage radiotherapy Hodgkin's disease patients can be expected to live out normal life spans, if the disease is localized and if adequate treatment is given. Thus it becomes important to establish the extent or stage of the disease.

For this reason a great deal of emphasis must be placed on determining the extent of disease or staging. Staging requires a careful history and physical examination. In the presence of hilar adenopathy, lung tomograms are done looking for small areas of parenchyneal involvement. A detailed skeletal survey and the use of calcium or strontium radioisotopes for scanning of the bone is also done. Probably the most significant advance in determining disease extent has been the use of lymphangiography which makes it possible to determine the presence of disease in the retroperitoneal space. This procedure has been very useful in defining those patients who are candidates for curative radiotherapy. A bone marow examination, including a needle biopsy of the bone marrow, is also done looking for bone marrow invasion. Liver function tests and radioisotope liver scans are attempts to look for involvement of that organ.

Table I defines studies of Hodgkin's disease as proposed at a recent conference.[3] Stage 1 is disease limited to one anatomical region. Stage 2 is disease limited to two or more contiguous or noncontiguous anatomical regions as long as the sites are on the same side of the diaphragm, either above or below. Stage 3 is where the disease is

I. Ridgeway Trimble Fund Lecture. Presented at 169th Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, April 1967.

Table I

STAGE 1	**Disease limited to 1 anatomic region or to 2 contiguous anatomic regions on the same side of the diaphragm**
STAGE 2	**Disease in more than 2 anatomic regions or in 2 non-contiguous regions on the same side of the diaphragm**
STAGE 3	**Disease on both sides of the diaphragm, but not extending beyond the involvement of lymph nodes, spleen, and/or Waldeyer's ring.**
STAGE 4	**Involvement of the bone marrow, lung parenchyma, pleura, liver, bone, skin, kidneys, gastrointestinal tract, or any tissue or organ in addition to lymph nodes, spleen, or Waldeyer's ring**
SUBCLASSIFICATION	
A	**Absence of systemic symptoms**
B	**Presence of fever, night sweats, or pruritus**

above and below the diaphragm, but still limited to nodal tissue. In Stage 3 the disease does not involve the bone, bone marrow, lungs, pleura, or liver. The spleen is considered lymph node tissue. Stage 4 is disease in non lymph node areas.

Another factor that has been shown to be related to survival and prognosis is the presence or absence of symptoms including fever, night sweats, and pruritis. Thus, the patient may be in any one of four stages and be symptomatic (B) or asymptomatic (A).

To illustrate the value of lymphangiography and staging, in a study at Memorial Hospital Lee has shown that in patients who present with a groin node, 6 of 6 (100%) had abnormal lymphangiograms.[4] On the other hand, when the presenting single area is in the cervical region, less than 10% of these patients had abnormal lymphangiograms. In patients who were clinically stage 2, where the disease was palpated only above the diaphragm, and who were symptomatic, 90% were found to have disease in the retroperitoneal space. Therefore, lymphangiography more clearly defines those patients who would not benefit by extensive treatment to the neck and mediastinum. On the other hand, it would be encouraging to find that the patient has disease in the neck or mediastinum, but not in the retroperitoneal space.

Kaplan[5] has shown that the percentage of recurrences in any one disease area was inversely related to the dose of radiation administered. In this report 80% of the patients had a recurrence when only very low doses of radiation had been administered. At 1000 rad tumor dose 60% had recurrences. However, if 4000 rads were administered the incidence of occurrence is only about 4%. Therefore, it is exceedingly important to make sure that the patients receive high doses of radiotherapy when the disease is localized. Easson was one of the first investigators to show that patients with localized Hodgkin's disease treated with high dosage radiotherapy and followed for up to 15 years have a normal expected survival after a slight initial decline in the first 2 to 5 years of follow up.[6] Accurate staging obviates the morbidity associated with high dosage extended radiotherapy in those patients with extensive disease.

What about the rest of the patients with stage 3 and 4 disease who represent about 60% of the patients with Hodgkin's disease? This group of patients should get chemotherapy.

One of the first chemotherapeutic agents used was "a nitrogen mustard," given in a dose of 0.4 milligrams per kilogram as a single injection or divided over 4 days. Nausea, vomiting and bone marrow depression occur with this agent. Another alkylating agent is *chlorambucil*, which is given orally in a dose of 0.1 to 0.2 milligrams per kilogram. It also causes bone marrow toxicity.

One of the newer alkylating agents is *cyclophosphamide*. It also causes the same kind of toxicity, nausea, vomiting, and bone marrow depression as the other alkylating agents, but may also produce alopecia or hemorrhagic cystitis. This compound can be given either orally or parenterally.

The "vinca" alkaloids, *vinblastine* and *vincristine*, are not alkylating agents, and they may be effective when alkylating agents are not. The vinca compounds cause bone marrow depression, but in addition, cause some degree of neurotoxicity manifested by numbness of the fingertips and peripheral nerve palsies.

Some of our own studies have suggested that *vinblastine* is as good as an alkylating agent as initial treatment in patients with Hodgkin's disease.[7]

Corticosteroids are useful in the treatment of thrombocytopenia or hemolytic anemia due to hypersplenism. Of the newer agents, *ibenzmethy-*

zin is one of the most effective. This compound is effective in patients refractory to both alkylating agents and the vinca compounds.

What do we have to know to use these agents in the best possible way? How can we achieve the best response or remission? Is it better to maintain a remission or to treat intermittently? These questions were asked and answered in a cooperative study by the Eastern Solid Tumor Group and Acute Leukemia B Group.[7]

In this study approximately 400 patients with malignant lymphoma were randomized to *cyclophosphamide* or to one of the two vinca alkaloids. Those patients who went into remission were then re-randomized to a maintenance regime that consisted of either *cyclophosphamide* or a placebo. These patients who received a placebo were than treated intermittently with parenteral *cyclophosphamide* on an intermittent treatment schedule.

In patients with Hodgkin's, *cyclophosphamide* treatment resulted in a complete plus partial response rate of 52%. In a comparable group of patients treated with *vinblastine* 76% of the patients had responses. Thus, for patients with Hodgkin's disease with no prior therapy, the response rate to *vinblastine* was better than it was to *cyclophosphamide*. In patients with lymphosarcoma the converse was true. The response to *cyclophosphamide* was better than to *vincristine*. In reticulum cell sarcoma patients no differences were noted between the two treatments. The remission duration for all these diseases was longer when maintained with an oral daily dose of *cyclophosphamide*. However, the intermittent type of treatment was as effective as the daily continuous treatment.

In patients with acute leukemia several drugs are effective in producing disease remission and combination chemotherapy is very effective in producing as well as prolonging remissions. We have seen that several agents are also effective in patients with lymphoma. What would combination chemotherapy do in lymphoma patients?

At the National Institutes of Health a preliminary study of combination chemotherapy was done by Doctors DeVita, Moxley, Brace, and Frei.[8] Ninety three percent of the patients had antitumor responses with combination chemotherapy and 86% of these patients had complete remissions. What was also exciting, was the finding that the duration of remission was exceedingly long and longer than expected following single drug treatment.

To follow up on this observation, at the National Institutes of Health, we have used in combination "nitrogen mustard," *vincristine, ibenzmethyzin* and *prednisone* for a 14 day treatment cycle and repeated after a two week rest for 6 cycles. This study was done in collaboration with Dr. Serpick of the Baltimore Public Health Service Hospital. Of the initial 30 patients on study, 83% of these patients had complete remissions. Of the patients who entered a remission, the mean duration of remission is in excess of 12 months. Only 4 patients have relapsed. We hope that some of these patients might indeed have very long remissions, indicating that the tumor population has been reduced to extremely small numbers.

I have talked about new concepts of management of patients with malignant lymphoma very rapidly. As I have tried to point out, we do not have to be pessimistic. We should examine these patients very carefully. The disease extent should be carefully documented using all the latest procedures. The treatment should be one most compatible with our latest information.

CYTOXAN—*cyclophosphamide*
DELTASONE—*prednisone* (Deltra, Meticorten, Paracourt)
LEUKERAN—*chlorambucil*
NATULAN—*ibenzmethyzin* (Methydhydrazine)
ONCOVIN—*vincristine*
VELBAN—*vinblastine*

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MEDICINE'S NOT SO SILENT PARTNER

CONGRESSMAN DURWARD G. HALL
Representative from Springfield Missouri.

Since that crucial vote in the U.S. House of Representatives on April 8, 1965 when 236 House members defeated 191 opponents of federal medicine and *Medicare* started on its way—our profession has been asked by federal government officials to join in partnership with the federal government, which is building bridges these days.

Leaders in all branches of Medicine freely offered their time and experience attending advisory committee meetings held in Washington, D.C. and Baltimore. Even some of the most liberal members of the radio, television, press, and periodical world who had been chewing on physicians for 20 years commended the profession's new attitude of cooperation.

I, for one, urged cooperation then, and I urge it now, but its time to blow the whistle at the *fouls* being committed by Medicine's new "partner," or "intervener," the federal government. I know of no other profession, group or industry, certainly not labor, not the legal profession, not the professional chemists, or the professional engineers, who in spite of their good works and contributions to society, are the victims of such malicious invectives and accusations, as is the medical profession.

In spite of being the only group subject to the draft up to age 35, in spite of the fact that many physicians give so generously of their time caring for the indigent, on unpaid hospital and other medical committees and boards, in medical missions in Viet-Nam and throughout the entire world, there is a growing long list of current smears, legal actions, punitive investigations, and intended regulations, some of which I will cite, and all of which demonstrate that with a friendly partner like this, who needs enemies?

Let me cite a few examples: . . . The *Medicare* law's legislative author, John S. Millis Ph.D., guaranteed on the floor of the House of Representatives that the Social Security Administration would not use the new law to disturb existing patterns of medical practice. Yet Mr. Robert M. Ball, the Administrator, now proposes that hospital-based physicians, especially the pathologists and radiologists, become employees of hospitals.

During the testimony before the House Ways and Means Committee prior to passage of the legislation *HEW* officials vowed they wanted only to cover the 65 and older members of society, yet in the first session of Congress following enactment of the law, coverage of the disabled is requested—irrespective of whether such person is able to afford his own medical expenses.

Though the law guaranteed two modes of payment for physicians, ie, direct billing using receipted bill, or by the assignment method. Just three weeks ago organized labor stumped the nation and filled the press with charges that organized Medicine was ruining the program by not using the assignment route exclusively.

HEW officials, behind closed committee doors, sought to require a statement by the physician on his receipted bill that charges shown were his total charges, thus permitting the federal government to exercise fixed-fee-control over any physician in the *Medicare* program. This isn't "keeping the faith, baby," if you ask me. *HEW's* own testimony shows about half the doctors have used the assignment method during the first 6 months of the program.

Given at the Annual Meeting Conference of Presidents, Chalfont-Haddon Hall, Atlantic City, NJ, June 17, 1967.

Disregarding the advice of the medical profession, our fair-weather partner sends its emissaries throughout the land, at the taxpayer's expense, in support of the use of "generic-drugs-only" in welfare programs.

Pro-Administration Senators Phillip Hart and Gaylord Nelson, who possess not a single hour of medical credit in their educational backgrounds, and whose professional staff rosters fail to include any medically trained personnel unless you count hangers-on of the Kefauver inquisition as such, tell the American people, who have the finest medical system in the world, that physicians must:

(a) Turn over to the optometrists some elements of care and treatment of the eye

(b) Must relinquish to the druggists the right to select from their stocks of generic drugs the drug of the company which offers to the druggist the highest mark up

(c) And, they would deny physicians the right to prescribe either a generic or trade name drug.

Now Webster defines partner as "—An associate; sharer; participant." The federal government is hardly living up to its role in this definition when its *OEO* opens neighborhood clinics in cities where the local medical society's notice of the event is seen for the first time in a copy of the evening paper of the day of the grand opening. This has happened in several places, most recently, in my own state, in Kansas City. Nor is the government playing the game when, in its demonstration cities there is provided mortgage guarantees, wherein perference is given to those groups who offer prepaid care—these usually are labor organizations' plans wherein physicians are hired on a salary and their earnings exploited in a way contrary to medical ethics.

Nor is the federal government a friendly partner when in return for such good deeds as the voluntary *Viet-Nam Medic Program* for the civilians of that war torn country, its Commissioner of Internal Revenue proposed regulations to tax at the rate of 48% net, advertising revenue of national and state medical journals and the journals and magazines of nearly every cultural organization in this country including the Boy Scouts and the Girl Scouts, the American Bar Association, the American Farm Bureau, the US Chamber of Commerce. I could go on naming some 600 educational, scientific, service and cultural organizations whose members are from the professions, business and labor. These proposed regulations are based upon a 1950 (17 year old) law originally enacted by Congress to curb the abuse of tax free universities owning and operating manufacturing businesses in competition with tax paying businesses.

Our friendly partner's *IRS* has recently notified the *Student American Medical Association* that it is recommending withdrawal of the Association's status as a tax exempt organization. *IRS* says the group derives most of its income from advertising revenues in its magazine, the *New Physician,* and from sales of life insurance to its members.

Though we all know that voluntary community blood banks are organized "not for profit," and reduces costs of medically needed blood, yet our "friendly" partner's *FTC* claims they are a business, and in interstate commerce, and therefore are subject to the anti-trust laws.

Our friendly partner's Justice Department has filed a civil anti-trust suit charging the College of American Pathologists and its members with conspiring to monopolize the medical laboratory testing industry by price-fixing and forcing laboratories, owned by non-members—out of business by what it called "boycotting agreements." The College pointed out that the timing of this action, coming at the inception of *Medicare* and immediately following the *AMA* Annual Meeting, makes it appear that this is but the first step in a campaign of harassment of the entire medical profession by the government.

There are times when the American public can hardly escape the conclusion that the administration in power is deliberately out to destroy the good name of the American physician, and to make him a subject of ridicule and contempt. For those who in one pious breath attack "McCarthyism" and in the other breath use such broad brush methods of innuendo, there is a double standard of immense contradictions.

I am still convinced that cooperation is the best road to travel, but cooperation which must be in its best and truest and fullest meaning. It must work both ways, and those representing *quality* care of patients must have the guts to stand for belief and principle.

PUBLIC RELATIONS IN ACTION

Robert B. Goldstein, MD, Chairman, Public Relations Committee, Medical and Chirurgical Faculty of the State of Maryland

It is interesting to me that today's seminar is held in this particular room called Osler Hall, named for Sir William Osler, Professor of Medicine at The Johns Hopkins Medical School at the turn of the century. As you look around this room and gaze upon the portraits of the distinguished gentlemen in high wing collars, frock tail coats, beards and moustaches, remember you are looking at men who practiced medicine in an era far removed from the one we practice in today. Their era was one where the physician was placed high on a pedestal and he could do no wrong. He was thought of as a healer, friend, minister and adviser. He did not have to worry about such things as insurance forms, government controls and regulations, getting hospital beds and filling out charts to the extent that you spend more time with paper work than you do with the patient.

Today the physician is not on that same pedestal. In the eyes of many he is a wealthy, money-hungry individual who drives a big automobile and does not work on Wednesday afternoons, Saturdays and Sundays and who will not make house calls or night calls.

Since the physician of today tends to be pictured this way, we must take a good look at ourselves and make changes where necessary. Today more people are getting better care than ever before and yet physicians cannot spend as much time with the patient as they desire. This is where the medical assistant takes over. Whether this person be a nurse, technician, secretary or receptionist makes no difference. To have a smooth running office and satisfied patients certain principles must be carried out. This is *Public Relations from the Doctor's Point of View.*

*Presented at Medical Assistants' Seminar, held at the Faculty Building, Wednesday, April 6, 1966.

As his assistant you are his representative in the eyes of all who enter his office. The doctor is known not only by his own good works, but by the deeds of his assistant acting for him. Every patient, actual or potential, who comes into the doctor's office deserves courtesy, prompt and sympathetic attention. Thus every patient forms an impression, the degree and extent of which is measured in the public eye. Every word, act and attitude of the medical assistant should reflect confidence and admiration for her employer.

Until recent years, the medical assistant's duty was largely restricted to secretarial duties. However, today the demands are different. Most doctors now desire a receptionist, a secretary, an office nurse and a laboratory technician all rolled into one. This is the well-trained medical assistant. The Medical assistant receives with pleasantness and dignity every person who enters the doctor's office, whether he be patient, book publisher, drug salesman, insurane broker or the doctor's friends or relatives. She also answers the telephone in a courteous and diplomatic manner. A personality that pleases others amounts to more than personal satisfaction; it is a definite professional advantage.

The public likes fair play. When a number of patients are in a reception room never let it be felt because you showed an apparent socialite directly into the doctor's consultation room that he caters to the rich or that he has favorites. Such an act on your part is an injustice to his character. You must represent him in the public eye as having an attitude of fair play for all—rich and poor alike.

As a receptionist, one plays the part of hostess

and no form of hospitality should be lacking. In the case of the medical colleague who comes by without an appointment or steps in for an unscheduled exchange of opinion, his time is as important as that of the doctor whom he comes to see. Professional courtesy demands that the receptionist notify her employer at once and show him to the consultation room as soon as possible.

This might be very obvious to you but let me recite an example of *non*-public relations in action.

A practitioner who referred much work to an ear specialist had the occasion to take his 12 year old son to this doctor for consultation. On arrival, the indifferent secretary did not show the least interest in their presence. After waiting for half an hour, the practitioner approached the secretary and asked if the doctor was there, and introduced himself by his professional title. Her reply was, "Yes, he is in but he is busy now."

In response to the question as to how long he would have to wait, she said, "I don't know, he'll probably be some time yet."

"I'll have to step downstairs to make a phone call to cancel another appointment, will it be alright if I leave my son here for a few minutes?" the doctor asked.

Her reply was short. "Indeed, I don't know, it's your child, suit yourself." The physician did suit himself and needless to say he did not refer any more patients either. He felt that all his patients were treated in the same caustic manner as he was.

All that was needed here was a little pleasantness. I realize that it is not easy to be pleasant as one nears the end of the day, but every patient needs good humor, sympathy and a quiet manner, no matter how weary or upset the medical assistant may be personally.

One doctor asked his very efficient and sophisticated secretary to break down and smile once in a while. She replied that she always, "felt so silly when she smiled." Perhaps she did not value the healing quality of pleasantness as much as she valued what someone might think of her.

A medical assistant should study the role of her doctor-employer so that in the act of assisting him there may be a perfect coordination in the public eye. The relationship between the doctor and his medical assistant is very close. As is obvious when one considers how often the nature of the works brings the doctor and his assistant together in treating patients. The personality and the character of the medical assistant can do much to attract patients and keep the doctor's practice in good repair.

Occasions will arise when it is necessary to save your doctor's "face", this occurs to all of us. One afternoon when I was quite late the secretary observed an undercurrent of growing impatience in the reception room. Instead of remaining indifferent to this feeling or showing annoyance at its demonstration, the secretary revealed a sympathetic concern for those people who were involved in a difficulty for which neither they nor she were responsible.

At the same time, she managed to remain loyal to me. Her tact and thoughtfulness allayed their impatience and retained their good will.

For the most part, those who come to a doctor's office will be patients. A high degree of intelligence is needed to increase in them a feeling of their own individuality and to show them that their best interests are being respected. The lesser number of visitors consists of non-patients; detail men, insurance agents, and others; that is, the general public with whom it is diplomatically advantageous to maintain proper and helpful relations at all times. A golden opportunity may be lost as the result of a poor reception. The receptionist with a quiet and pleasing manner and a sense of timing and tact is one of the greatest assets that any doctor can have.

The patient feels primarily concerned about himself; secondarily interested in the doctor who is to help him; and only casually, if at all, interested in you. Nevertheless, the patient sees you first, and you must create the refined, pleasant and comforting atmosphere of the office. The place where you preside should be for the moment a refuge that will inspire confidence and release unnecessary tension. The medical assistant in her role as receptionist is called upon to relate the patient smoothly and pleasantly to the busy doctor and to make the experience of spending money for medical attention satisfying and agreeable.

The medical profession frowns upon any form of commercial advertising to attract the general public. However, this does not mean that a doctor cannot take advantage of the fact that his reception room is actually the "show window" of his profession. The medical assistant will be courte-

ous and efficient at all times because she realizes the importance of personal contacts and the necessity of tact in handling all who come: patients and non-patients; the well educated and the ignorant; colleagues and tradespeople; friends and relatives. She will recognize the dual role as a guardian of the goodwill of the public as well as the custodian of her employer's time and energy.

Situations will arise such as a referring doctor forgetting to make an appointment for his patient, and she arrives during a busy afternoon schedule. The able assistant, aware of good public relations will handle this incident adequately with no one being the wiser. However, I have experienced the opposite on occasions and it has hurt the physician considerably.

A feeling of security is an important factor that most patients desire and this is done by creating an atmosphere of confidence. Do not allow case histories, reports, financial statements and doctor's correspondence to lie carelessly exposed on your desk. Many patients do not like to think that their personal correspondence with the doctor may be handled by you. I have been in offices where the indifferent receptionist actually shouted into the waiting room to a new patient and asked for the following information: Why are you here? How old are you? Do you have insurance? And who is going to pay the bill?

I find that the waiting room serves its purpose to further public relations. The public relations section of the American Medical Association has much information available in pamphlet form that is geared for the layman's information on home treatment for emergencies, use of drugs, knowledge for baby-sitters, etc. And, more recently, information on Medicare. As a medical assistant you will have to be aware of these problems because you, as well as the doctor, will be asked for answers and opinions.

Another path to good public relations that occurs in my office and for which I take no credit is as follows. My secretary, faithfully, scans the paper for the death notices, marriage licenses and any news of our patient or their families. An appropriate letter or card is sent. The impression this personal touch leaves with the patient or his family is tremendous. Patients whom I admit to the hospital for surgery always receive a card—not from me but from my medical assistants. When a patient is discharged from the hospital, one of the girls always calls in three or four days to inquire as to the patient's convalescence. These are trivial, time-consuming aids that pay big dividends.

The telephone may be called the threshold to professional success. Good telephone technique is most important in a doctor's practice because much of his professional business comes to him and is maintained through its use. Do you have what the New York Telephone Company calls, "A Voice With A Smile?" Do you telephone others as you would be telephoned to? Have you a pleasing telephone personality? If you answer these questions in the affirmative, you possess an important requisite to medical assisting.

A doctor will forgive much and will overlook some shortcomings when they are compensated for by other more worthy talents; but he will not tolerate a medical assistant who turns patients from his telephone door.

The object of proper telephone technique is to attract new patients to your doctor's office and to serve every person who calls with such courtesy and satisfaction that he will enjoy his professional telephone relationship with you.

This phase of public relations was thought to be so important that one county medical society in Oregon scheduled a course in telephone techniques for medical assistants working in doctor's offices. It proved to be sound public relations because now instead of hearing a tiger on the line, you can hear a smile on the line. As a result 1965 was the year of the tiger on Madison Avenue, but now in the medical offices of Multinomah County, everyday one can hear the voice of the turtledove. After all, a coo is gentler than tiger talk.

While doctors vary, according to their specialties, as to the amount of medical assistance they require, nevertheless every doctor desires a trained and efficient co-worker. He needs a secretary who can save his valuable time, a technician who can submit reliable reports and, above all a person who will meet his patients with intelligence, tact, sympathy and integrity. These qualities are at the heart of his medical practice and with them he begins his art of healing.

This is Public Relations in Action from One Doctor's Point of View.

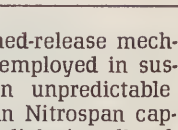


Unique Nitrospan micro-dialysis process* adds an important dimension–TIME–to nitroglycerin therapy

elps decrease frequency and severity of attacks; often ıcreases exercise tolerance. Decreases need for sub-ngual nitroglycerin, increases patient confidence. mooth, continuous release independent of gastrointes-nal functions reduces headache and other side effects ıat might result from peak concentrations of tablet or ıtermittent-release preparations.

ıdication and Dosage: For prophylactic use only in an-na pectoris, 1 capsule every 12 hours. **Precautions:** For rophylaxis only, not for relief of acute anginal attacks. olerance to nitrites may develop on long-continued use. **ontraindications:** Idiosyncrasy to nitroglycerin, and arly myocardial infarction. **Side Effects:** With use of itrites, transient headache, postural hypotension, nausea and vomiting may occur. Overdoses may cause flushing, dizziness, tachycardia, headache and syncope.

***The micro-dialysis cell.** Nitrospan's timed-release mechanism is different from those usually employed in sustained-action capsules, which rely on unpredictable digestive processes. The nitroglycerin in Nitrospan capsules is contained within hundreds of dialysis cells of controlled permeability. The contents of each micro-dialysis cell are released by diffusion rather than disintegration, at a continuous rate independent of gastrointestinal action. Only the presence of fluid is required.



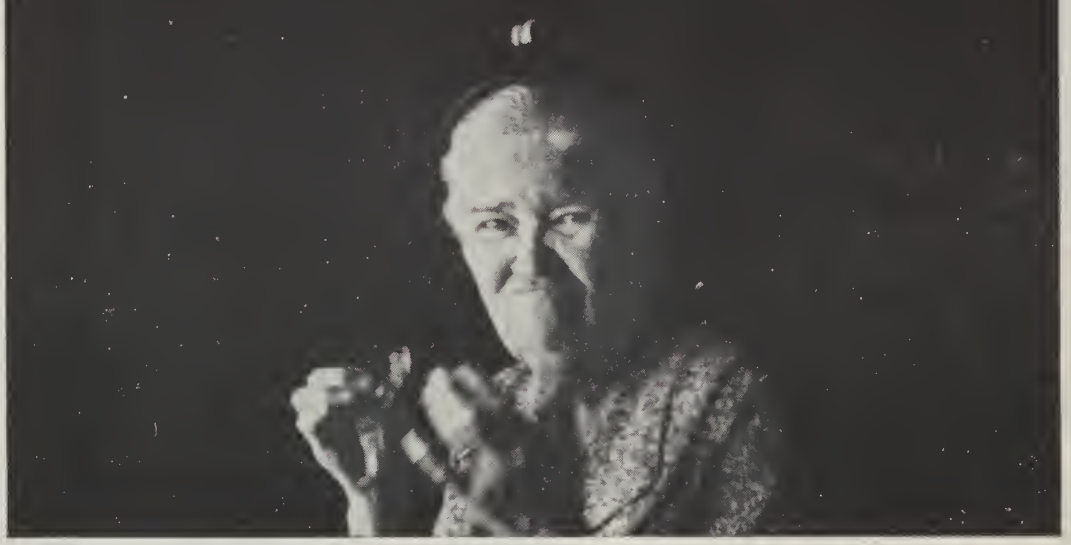
NEW from USV **NITROSPAN®** CAPSULES

brand of **nitroglycerin** 2.5 mg. in micro-dialysis cells

USV PHARMACEUTICAL CORPORATION, 800 Second Avenue, New York, N.Y. 10017

IRON DEFICIENCY

ANEMIA



Imferon®
(iron dextran injection)

There's as much iron . . . 250 mg. . . . in a 5 cc. ampul of Imferon (iron dextran injection) as in a pint of whole blood. When iron deficient patients are intolerant of oral iron . . . or orally administered iron proves ineffective or impractical . . . or if the patient cannot be relied upon to take oral iron as prescribed, Imferon (iron dextran injection) dependably increases hemoglobin and rapidly replenishes iron reserves. Precise dosage is easily calculated.

LAKESIDE

IN BRIEF: ACTION AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion as a source of iron; infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

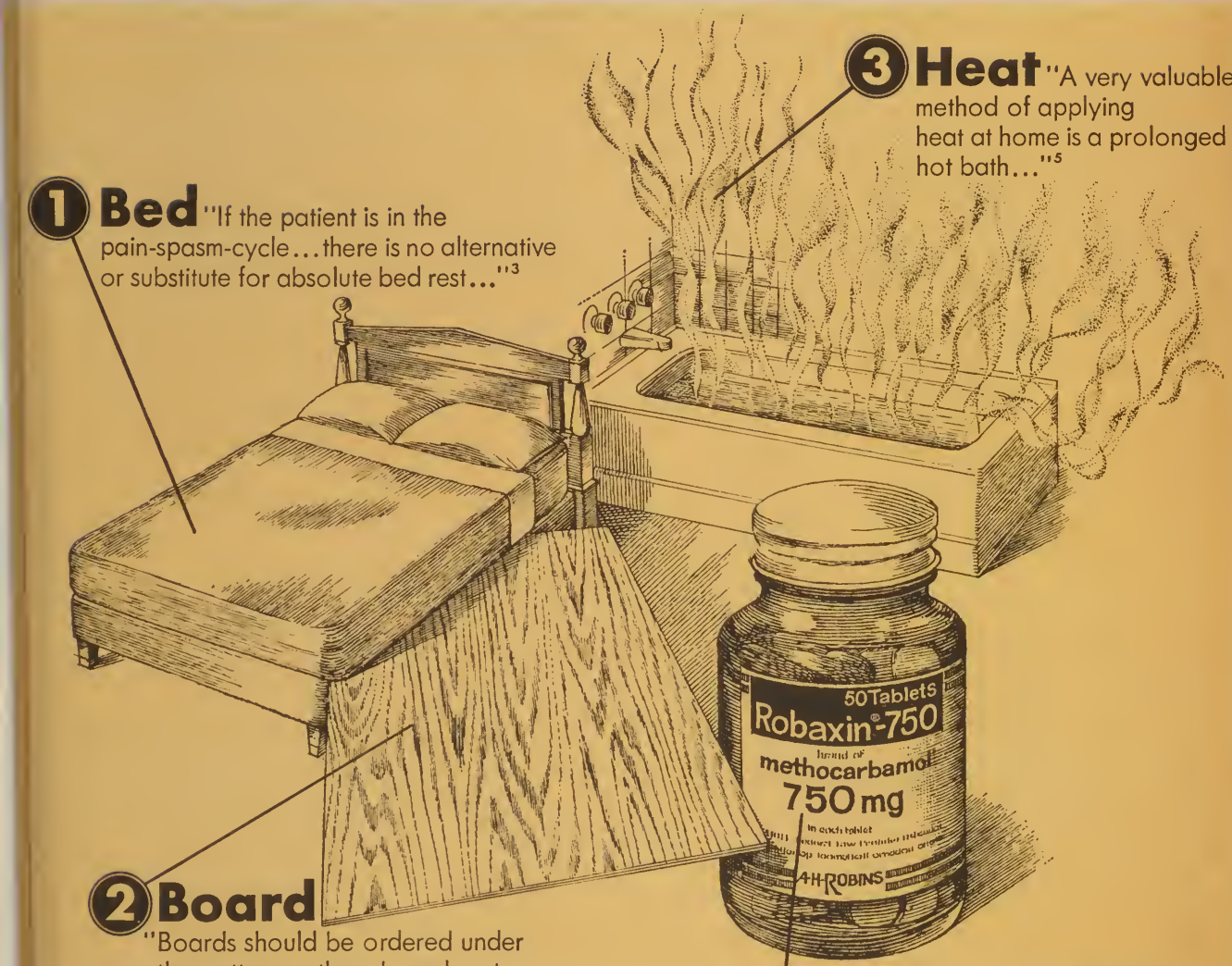
SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

LOW-BACK PAIN

A CONSERVATIVE, FOUR-POINT PROGRAM

The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.[1,2] For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:



1 Bed "If the patient is in the pain-spasm-cycle...there is no alternative or substitute for absolute bed rest..."[3]

2 Board "Boards should be ordered under the mattress...these boards act by immobilizing the spine..."[4]

3 Heat "A very valuable method of applying heat at home is a prolonged hot bath..."[5]

4 Robaxin®-750 (methocarbamol, 750 mg. capsule-shaped tablets) A well-tolerated[6] skeletal muscle relaxant, methocarbamol helps relieve spasm "...without interfering with normal tone and movement."[7] And there is little likelihood of sedation.[6]

ndicated for relief of skeletal muscle spasm. **Contraindicated** in ypersensitive patients. **Side Effects** (lightheadedness, dizziness, rowsiness, nausea) may occur rarely, but usually disappear on reduced losage. Hypersensitivity reactions develop infrequently. See product terature for further details. **Also available:** Robaxin® Tablets methocarbamol, 500 mg.) Robaxin Injectable (methocarbamol, 1 Gm./10 cc.)

References: (1). Godfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gottschalk, .A.: GP 33:91, 1966. (3). Rowe, M.L.: J. Occup. Med. 2:219, 1960. 4). Cozen, L.: South Dakota J. Med. 18:26, 1965. (5). Soto-Hall, R.: Med. Sc. 14:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteopath. A. 2:142, 1962. (7). Feuer, S.G., *et al.*: New York J. Med. 62:1985, 1962.

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NEW EVIDENCE:

Pro-Banthine® (propantheline bromide)
gives positive, selective benefits in gastrointestinal disorders.



Intragastric photograph of pyloric region showing complete relaxation of pyloric sphincter with 6 mg. of Pro-Banthine intravenously.

AN IMPORTANT PROBLEM in managing gastrointestinal disorders has been the choice of an anticholinergic agent which will act positively and selectively on the gastrointestinal tract without extensive secondary effects.

Recent direct observations with the cinefibergastroscope and intragastric photography[1] visually confirm previous evidence that Pro-Banthine does, indeed, possess such selective activity.

Barowsky and his associates demonstrated that a minimal dose of 6 to 8 mg. of Pro-Banthine intravenously produced complete relaxation of gastric activity. Secondary effects were not significant.

By contrast, it required 0.8 mg. or double the usual dose of atropine intravenously to achieve similar gastric relaxation. Side effects of this dosage of the belladonna alkaloid were pronounced. Ventricular rates were as high as 150 per minute.

For positive, selective anticholinergic benefits Pro-Banthine is indicated in patients with peptic ulcer, gastritis, irritable colon and other forms of gastrointestinal hypermotility.

Dosage: The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type ampuls of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

Contraindications: In glaucoma or severe cardiac disease.

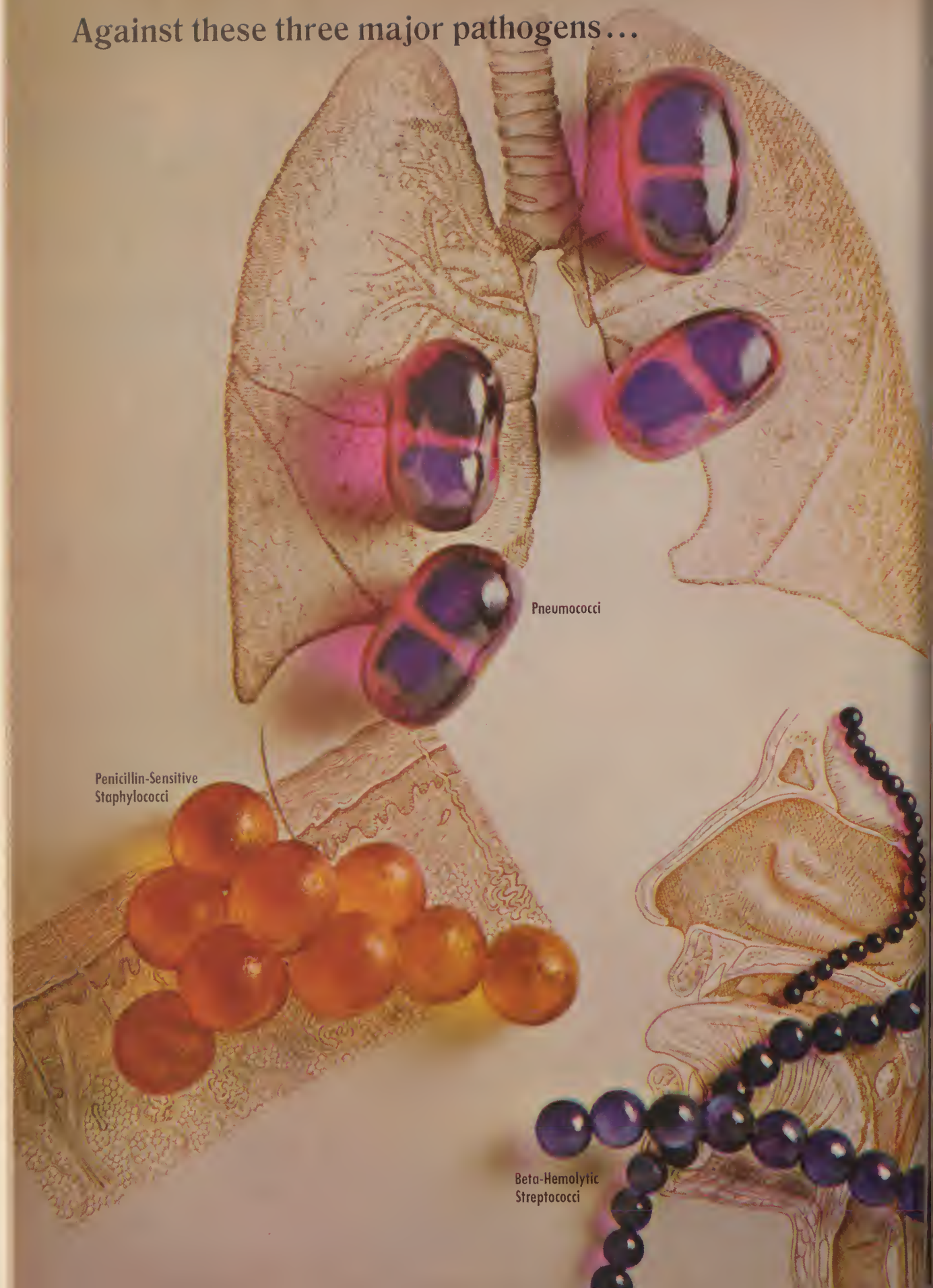
Precautions: Since varying degrees of urinary hesitancy may occur in the elderly male with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug.

Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

Side Effects The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

1. Barowsky, H.; Greene, L.; Bennett, R., and Buganza, G.: The Effect of Anticholinergic Drugs on Gastric Motility and Pyloric Function, Scientific Exhibit, Annual Convention of the American Medical Association, Chicago, Illinois, June 26-30, 1966.

Against these three major pathogens...



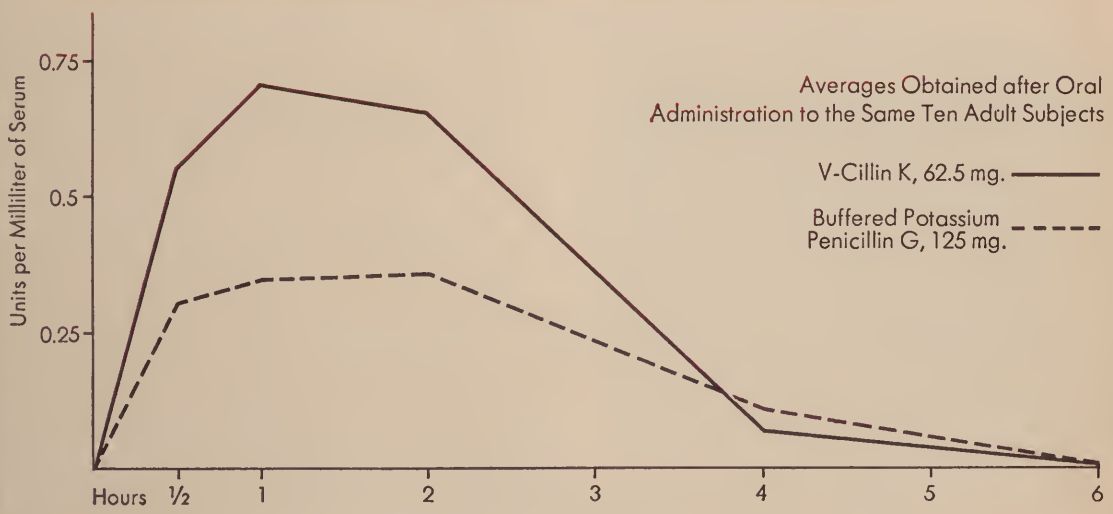
V-Cillin K® provides dependable oral antibacterial activity

because it combines a high degree of in-vitro activity...

Antibiotic	Staph. Aureus (Penicillin-Sensitive) MIC (mcg./ml.) Median	Range	Streptococcus, Group A MIC (mcg./ml.) Median	Range	Diplococcus Pneumoniae MIC (mcg./ml.) Median	Range
Penicillin V	0.02	0.02-0.04	0.02	0.003-0.4	0.01	0.005-0.2
Penicillin G	0.02	0.005-1.6	0.005	0.002-0.2	0.02	0.01-0.1
Methicillin	1.6	0.4-6.3	0.2	0.1-0.4	0.2	0.1-1.6
Oxacillin	0.4	0.1-3.1	0.04	0.02-0.4	0.1	0.04-0.8
Cloxacillin	0.2	0.2-0.8	0.1	0.1-0.8	—	—
Nafcillin	0.4	0.2-0.8	0.04	0.02-0.1	0.02	0.02-0.2
Ampicillin	0.2	0.1-0.8	0.02	0.01-0.04	0.02	0.01-0.04

Adapted from Klein, J. O., and Finland, M.: New England J. Med.,269:1019, 1963.

with high blood levels, even in the presence of food



Adapted from Griffith, R. S., and Black, H. R.: Current Ther. Res., 6:253, 1964.

V-Cillin K® Lilly 700867

Potassium Phenoxymethyl Penicillin

(See next page for prescribing informatio

New 500 mg. tablets...a more convenient way to give high doses



Description: V-Cillin K is the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly). This chemically improved form combines acid stability with immediate solubility and rapid absorption. Higher serum levels are obtained more rapidly with this penicillin than with equal oral doses of penicillin G. The higher serum levels and acid stability of V-Cillin K make it a more dependable penicillin for oral use.

V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

Indications: V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Warnings: In rare instances, the use of penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin and in those with bronchial asthma or other allergies. Resuscitative drugs should be readily available for emergency administration. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for relief of immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, its administration should be discontinued, and appropriate measures should be taken.

Adverse Reactions: Although serious allergic reactions are much less common with administration of oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it does possess a significant index of sensitization. The following hypersensitivity reactions associated with the use of penicillin have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: For Tablets V-Cillin K and for V-Cillin K Pediatric, the usual dosage ranges from 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants the daily dosage may be 50 mg. per Kg. of body weight divided into three doses.

Beta-hemolytic streptococcus infections without associated bacteremia may be treated with 200,000 to 400,0000 units three times a day. Therapy should be continued for a minimum of ten days to prevent development of rheumatic fever and/or other serious complications. Dosage for routine streptococcus prophylaxis in patients with a history of rheumatic fever or congenital heart disease may be 200,000 units once or twice daily. When such patients undergo tonsillectomy, tooth extraction, or other minor surgery, the prophylactic dose should be 500,000 units every six hours given two days prior to surgery and for two days postoperatively. If oral medication is not feasible on the day of surgery, parenteral therapy should be considered. Mild to moderately severe pneumococcus pneumonia has been treated effectively with 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be given every six to eight hours in conjunction with indicated surgical procedures.

For gonorrhea in males, 500 mg. (800,000 units) every four hours in three doses may be employed; in females, 500 mg. every four hours for six doses are recommended. Refractory infections generally respond to a second treatment three to four days following completion of the first. Treatment of gonorrhea with severe complications should be individualized, with prolonged and intensive treatment. Patients with suspected lesion of syphilis should have a dark-field examination before receiving penicillin and monthly serologic tests for a minimum of three months.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units) in bottles of 50 and 100; and 250 mg. (400,0000 units) and 500 mg. (800,000 units), in bottles of 24 and 100.

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Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

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HEPATIC VENOGRAPHY WITH CARBON DIOXIDE

DAVID B. GOLDENBERG, MD
AND
BYRON G. BROGDON, MD

The Department of Radiology,
The Johns Hopkins Hospital, Baltimore, Maryland

During review of a series of patients in whom carbon dioxide filling of the right atrium was performed for evaluation of pericardial effusion, it was observed that contrast visualization of the hepatic veins was obtained in 23 of 24 cases. In all of these, good filling of the right vein was obtained, usually to the level of the sixth bifurcation or beyond; because of its course and direction the left hepatic vein was ordinarily less extensively filled (Fig. 1). Carbon dioxide also refluxed down the inferior vena cava for variable distances, according to whether or not the patient's feet were elevated. Similar incidental filling of hepatic veins during gas studies of pericardial effusions was noted recently by Burko and Klatte.[1]

The morphological evaluation of the hepatic veins has been a difficult angiographic problem. Because of superimposition of branches of the portal vein, liver capillaries and the liver parenchyma, evaluation of the hepatic venous phase has been difficult with splenoportography.

Attempts at selective hepatic venography by retrograde injection of opaque contrast medium into the large trunks of the hepatic veins via catheter[2] have met with limited success. Nordenstrom[3] observed reflux filling of the hepatic veins in dogs when intrabronchial pressure was raised during right atrial and/or inferior vena cava injection. However, Nogueira's[4] attempt to utilize this technique for visualization of the hepatic veins in one patient failed. Tori and Scott[5] occluded the inferior vena cava in a dog some 2-3 cm. above the diaphragm by use of a balloon catheter. Subsequent contrast injection below the level of occlusion produced excellent retrograde opacification of hepatic veins. Norhagen[6] employed this technique in 45 patients with cirrhosis and hepatic neoplasms. He found the method to be associated with negligible risk, there being only occasional extrasystoles during inflation of the balloon catheter in the right atrium.

Although the method of Norhagen is satisfactory for demonstration of hepatic vein morphology, it is cumbersome to employ, requiring a double retrograde catheter technique. Visualization of he-



Fig 1
Proximal portion of inferior vena cava and right and left hepatic veins filled with carbon dioxide. (left lateral decubitus position)

Dr. Brogdon is now at the University of New Mexico School of Medicine, Albuquerque, New Mexico. This work was supported in part by USPHS Grant #5TO1 GM 01328 from the National Institute of General Medical Sciences.

patic veins with carbon dioxide promises to be a simpler method.

Method

With the patient lying on a stretcher against an upright Bucky cassette holder, scout film examinations of the chest and abdomen were obtained in the left lateral decubitus position. The foot of the stretcher was elevated approximately twenty degrees with respect to the head. Subsequently, a 16 gauge needle, connected to a tank of pure carbon dioxide by a three-way stopcock, was inserted into an antecubital vein. A 100 cc. syringe connected to the stopcock was repeatedly flushed with carbon dioxide to clear the system; then 100 cc. of carbon dioxide was hand-injected rapidly. Two 14 x 17 inch x-ray films were exposed sequentially as soon as possible thereafter. The patient was maintained in the left lateral decubitus position for at least five minutes following roentgenography in order to insure absorption of the carbon dioxide.

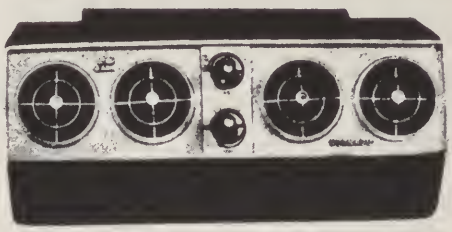
Comment

The hepatic veins may be occluded by thrombus or tumor arising either locally or by extension from the interior vena cava. Rarely, a congenital or acquired stricture is responsible for hepatic vein occlusion. The changes produced in the liver are those of severe congestion or cardiac cirrhosis, depending on the duration of the disease. Hepatic vein occlusion must be considered in the differential diagnosis of any case in which there is progressive enlargement and tenderness of the liver with rapid accumulation of ascites. Because of the technical difficulties pointed out above, morphological evaluation of hepatic veins rarely has been possible in the past. Reflux visualization of the hepatic veins and vena cava by carbon dioxide is a simple and expedient solution to this problem (Figure 1).

Additionally, although we have had no opportunity to apply this in clinical practice, carbon dioxide hepatic venography should prove useful in cases of deep-seated or central hepatic metastases where isotope scanning procedures may yield equivocal or negative results.

Summary

Intravenous injection of carbon dioxide is a simple and effective technique for radiographic visualization and evaluation of the hepatic venous system.

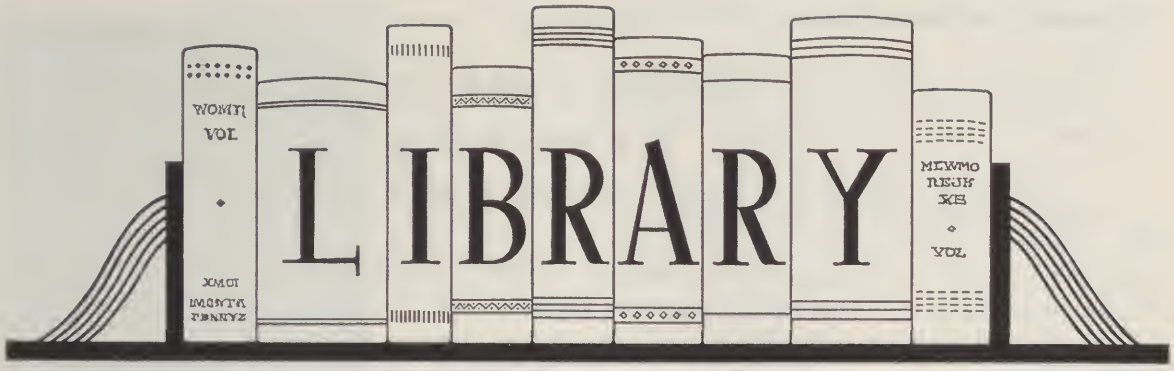


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Louis Krause, MD, Chairman
Library and History Committee

Elizabeth Sanford
Librarian

Miami Conference

Baltimore and Maryland librarians were very obvious at the meeting of the Medical Library Association for its 66th Annual Conference in Miami, June 11-18th, 1967. With representatives from the libraries of the two medical schools, Welch Medical Library and the Health Sciences Library; the National Library of Medicine, Medical and Chirurgical Faculty, and at least four local hospitals, including several hospitals outside the metropolitan area.

While the registration figure was near 600, the hotel very large, and the meetings diversified, there really never was a time when all Maryland delegates got together for a library talkfest. This suggests an idea for next year or, at least, some future planning, since the Denver librarians have their program for the 1968 meeting well organized already.

One of the most interesting presentations was the Sunday evening *Clinic on Medical Library Buildings*. Three building plans were presented. (1) The Library of Science and Medicine, Rutgers University, New Brunswick, New Jersey, by James Barry, Librarian, with Joan Titley, Librarian, Medical School, University of Louisville, Kentucky, as critic. (2) The Medical Library of the University of Nebraska, presented by Mrs. Bernice M. Hetzner, Librarian, and criticized by David A. Kronick, Librarian, South Texas Medical School, San Antonio. (3) The Division of Health Affairs Library, Chapel Hill, University of North Carolina, presented by Myrl Ebert, Librarian, and criticized by Sam Hitt, Librarian, Health Center, University of Connecticut, Hartford.

Librarians presenting plans defended the arrangement, design and decor of their respective buildings, while both the critics and audience unhesitatingly pointed out disadvantages and flaws. This produced a lively discussion which lasted late into the evening.

The five *Continuing Education* courses offered on Monday included subjects such as Implications of Machines in Libraries, Systems and Analysis, Human Factors in Administration Specialized Subject Field of Dentistry, and "Techniques of Interlibrary Loans." Aside from flooded classrooms on the lower floors where these courses were being held, and knee deep water in many streets, the meetings and library tours progressed as scheduled.

Highlight of the opening session was the *Janet Doe Lecture*: "The Medical Library Association in retrospect, 1937-1967," by Gertrude L. Annan, Librarian, New York Academy of Medicine, New York. Our own Marcia Noyes was among the prime figures in organizing *MLA* and headquarters was 1211 Cathedral Street for some time.

The Medical Societies Group dinner was chaired by Wesley Draper, Librarian, Academy of Medicine of Brooklyn (New York). Mrs. Helen Kovacs discussed "relationships of the Medical

Society Library with the Medical School Library Functions.

Other subjects on the agenda for general sessions were the evolving educational objectives and librarianship and the newer media.

* * * * *

Physicians who expect to attend the semi-annual meeting of the Faculty and would like special subjects or titles brought to them in Ocean City should send requests to the library as soon as possible. This is a service the library staff in pleased to furnish.

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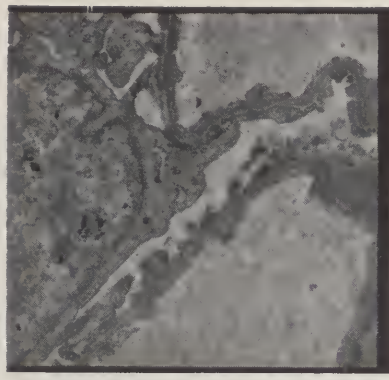
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MARYLAND SOCIETY OF PATHOLOGISTS INC.

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Pulmonary Function Tests for the Pathologist

The primary function of the lung is to adequately oxygenate and adequately remove waste CO_2 and H_2O from mixed pulmonary venous blood. To accomplish this, five general areas of activity are concerned, as follows: *ventilation,* for which *work* is necessary; *circulation, diffusion* and *gas exchange.* Each of these modalities may be measured, but, as Comroe emphasizes, ". . . physiologic tests indicate only how the disease has altered function; they cannot make an anatomic, a bacteriologic, or a pathologic diagnosis." In general, also, pulmonary function studies evaluate the *entire* lung, rather than any part of it. And so, to further paraphrase Comroe, they cannot tell where or what the lesion is; and they may not even indicate that there is a lesion. Therefore, as with all other laboratory tests, they simply supplement a good history and physical examination and the associated bacteriological, radiological, bronchoscopic, and pathological studies. Pulmonary function studies are not magical, any more than any other laboratory work is. If there is interference with a lung function by a pathological lesion and this interference falls within the parameters of available pulmonary function tests, they will measure it; if it does not, they will not.

Ventilation:

This modality is actually the movement of air in and out of the lungs; it is measured in terms of the four lung *volumes* and four lung *capacities.* The lung volumes are as follows: tidal volume (*TV*), inspiratory reserve volume (*IRV*), expiratory reserve volume (*ERV*), and residual volume (*RV*). The four lung capacities are the vital capacity (*VC*), inspiratory capacity (*IC*), functional residual capacity (*FRC*), and total lung capacity (*TLC*). Technically, none of these is a function test, but merely a measurable limit of ventilation. A spirometer will measure the *TV, IRV, ERV,* and *IC* and *VC.* The *FRC* is measurable by three different methods: the nitrogen wash-out (open-circuit), helium dilution (closed-circuit), or the body plethysmograph. The principal value of the plethysmograph, which actually measures thoracic gas volume, is that it will measure true *TLC,* whereas the other two methods will not measure non-ventilated lung areas. One may classify diseases which manifest themselves in measurable defects in lung volumes or capacities, as follows: those changing the anatomical amount of lung tissue, those affecting thoracic wall expansion, and those affecting diaphragmatic movement.

A corollary of and equally as important as the ventilatory volumes or capacities is the distribution of the air within the lung. In this regard, there is an *anatomic dead space* (ie, where no alveolar air exposure exists) and a *physiologic dead space* (in which inadequate circulation prevents gas diffusion in aerated alveoli). Only functional alveolar ventilation is ever effective, so that alveolar volume represents that portion of

the expired air with the same pCO_2 as pulmonary capillary blood and equals *TV* minus physiologic dead space volume. If ventilation is uneven, it is clinically manifest as increased work, decreased arterial pO_2 and increased pCO_2.

Work:

The muscles of respiration must overcome *elastic* resistance (lung and chest wall) and *frictional* resistance (principally due to airway air flow). The elastic resistance is measured in terms of *compliance,* which is volume change related to external pressure. The frictional or airway resistance is a function of alveolar pressure minus mouth pressure (air flow) and is measured in terms of three tests: maximum breathing capacity (*MBC*), timed forced expiratory volume (FEV_T), and maximal inspiratory and expiratory flow rates (*MIFR* & *MEFR*). Compliance is best measured with the plethysmograph; it is decreased in those diseases which interfere with lung expansion while the FEV_T, *MBC, MEF,* and *MIF* are decreased in diseases causing airway obstruction and air trapping.

Circulation:

It is obvious that adequacy of pulmonary capillary blood flow is equally as important to the organism as ventilation. The mechanisms which interfere with pulmonary circulation are anatomical shunts (cardiac or pulmonary), pulmonary vascular obstruction, and changes in blood flow (inflammation, atelectasis, and cardiac output). In the sense that it represents blood flow and does not take part in pulmonary gas exchange, the anatomic shunt is comparable to the anatomical dead space and is the only cause of hypoxemia not correctable by breathing 100% oxygen. Shunted blood includes both that through anatomical shunts as well as that flowing through physiological dead spaces. Shunts are measured by determinations of arterial pCO_2 and pO_2. Pulmonary blood flow is measurable by the Fick principle method (oxygen uptake/A-V oxygen difference), dye dilution, and the body plethysmograph, the latter measuring instantaneous capillary blood flow. Three other factors of importance in consideration of circulation are pulmonary vascular resistance, pressure, and volume. Resistance is measured as driving pressure in relation to blood flow. Pressure is measured by wedging a catheter into the smallest pulmonary artery possible or

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measurement of the left auricular pressure by trans-septal puncture technique. Pulmonary capillary blood volume is indirectly measured by measuring the CO diffusing capacity when breathing gas of a high O_2 and then a low O_2 concentration. The ratio of ventilation to perfusion (V/P) is extremely important, since the most common cause of clinical hypoxemia is the inadequate oxygenation of the pulmonary capillary blood as a result of alteration of the average ventilation/perfusion ratio of 4/5. Conversely, the arterial pCO_2 will remain stable as long as it is possible to compensate for a decreased circulation with an increased ventilation.

Diffusion:

This represent the movement of gas molecules from a region of higher concentration to one of lower concentration. It is obvious that diffusing capacity, then, is the rate of oxygen transferred across the alveolo-capillary membrane. Anything hindering this transfer by decreasing the total *area* of the alveolo-capillary membrane will impair diffusion. Diffusing capacity is measurable by determining the pCO in the alveoli after breathing air and then oxygen. The term "alveolo-capillary block" is probably a misnomer, since there is some evidence that thickness of the alveolo-capillary membrane is of no significance in diffusion. There may be secondary changes in the diffusing capacity because of a decrease in the amount of functioning lung tissue.

Gas exchange:

Measurement of the arterial blood gas levels reflects the adequacy of pulmonary gas exchange, whose purpose it is to provide the oxygen needed and dispose of the CO_2 produced by the body's metabolic processes. The biochemical relationship of blood gases with hemoglobin and the solution of gases in the plasma are relatively well understood. The transport of these gases across the alveolo-capillary membrane is related to the gradient between the pO_2 and pCO_2 in the alveoli and the capillary blood. Thus, the relationship between the levels of arterial oxygen when a patient is breathing normally and when he is breathing 100% oxygen may help to clarify a case of hypoxemia; such a change may be due to any disease process that decreases alveolar ventilation, impairs diffusion, produces an uneven alveolar ventilation/pulmonary capillary blood flow ratio, or causes a venous-arterial shunt.

In the above paragraphs, an attempt has been made to condense a vast amount of complex, inter-related, and often poorly understood material. It is hoped that too much will not have been lost in this summarizing.

W. Bradley King, Jr., MD
Assistant Professor of the Department of Pathology
University of Maryland School of Medicine, Baltimore

Comroe, Forster, Dubois, Briscoe, and Carlsen. *The Lung.* 2nd Ed. Year Book Medical Publishers, Inc., 1962 Chicago

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IN BRIEF.

Contraindications: History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. Withdrawal symptoms upon discontinuation have been noted in some patients exhibiting drug dependence through chronic overdose. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose; excessive, prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Withdrawal symptoms following abrupt discontinuance are similar to those seen with barbiturates. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance. Safety for use in pregnancy has not been established.

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Side Effects: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leucopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age. These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever and euphoria.

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The National Scene

In 1966, for the first time, expenditures in the United States for the maintenance of state and county operated mental hospitals exceeded one and one-quarter billion dollars.* This represented an increase of 8.2%, or 98 million dollars, over the previous year's comparable figure. Total maintenance costs have nearly doubled since 1956 and are now one-third higher than they were five years ago.

Hospital expenditures have continued to go up although the average number of patients in these facilities has decreased steadily. Nationally, a decline in the patient population of 16.8% (from 555,103 to 461,910) occurred between 1956 and 1966. As a result, the average cost of caring for one patient for one day has gone up substantially. In 1956, the national daily per capita was $3.26. By 1966, this had increased 137.1% to $7.73. Despite this marked improvement, expenditures per patient continue to lag behind comparable figures from federal (VA) psychiatric hospitals.

While these data reflect rising personnel-patient ratios, the current emphasis on psychopharmacology and other improvements in treatment services, they are primarily related to the rapidly increasing patient turnover resulting from shortened periods of hospitalization and the release or transfer to nursing homes of many long term patients. As indicated in the following table, both admissions and the net number of releases have risen considerably between 1956 and 1966. In fact, this rise has been so large that the average expenditure required to produce one net release is now less than it was ten years ago.

If present trends continue, the average daily cost per patient must be expected to rise 10% or more per year at the same time that the average total cost of each treatment episode declines further. The only alternative to continuing, uninterrupted increases in state psychiatric hospital expenditures is to reduce drastically the size of the patient population by (1) curbing the flow of admissions (2) further decreasing the average period of hospitalization and (3) transferring chronic, custodial patients to nursing home type facilities. This can be accomplished through closely coordinated programs offering a variety of community and hospital services to the mentally disturbed and through the implementation of current and new concepts for the prevention of mental illnesses.

FISCAL YEAR	ADMISSIONS	NET RELEASES	TOTAL EXPENDITURES	EXPENDITURES PER NET RELEASE
1956	185,597	145,313	$663,280,934	$4,564.49
1958	209,823	161,742	806,711,228	4,987.64
1960	234,791	192,818	916,236,166	4,751.81
1962	269,854	230,158	1,033,567,884	4,490.68
1964	302,946	271,506	1,133,015,675	4,173.07
1966	330,399	311,827	1,300,622,459	4,170.97

* Office of Biometrics, National Institute of Mental Health, Series *MHB-H11*, Provisional Patient Movement And Administrative Data-State And County Mental Hospitals-United States-1966.

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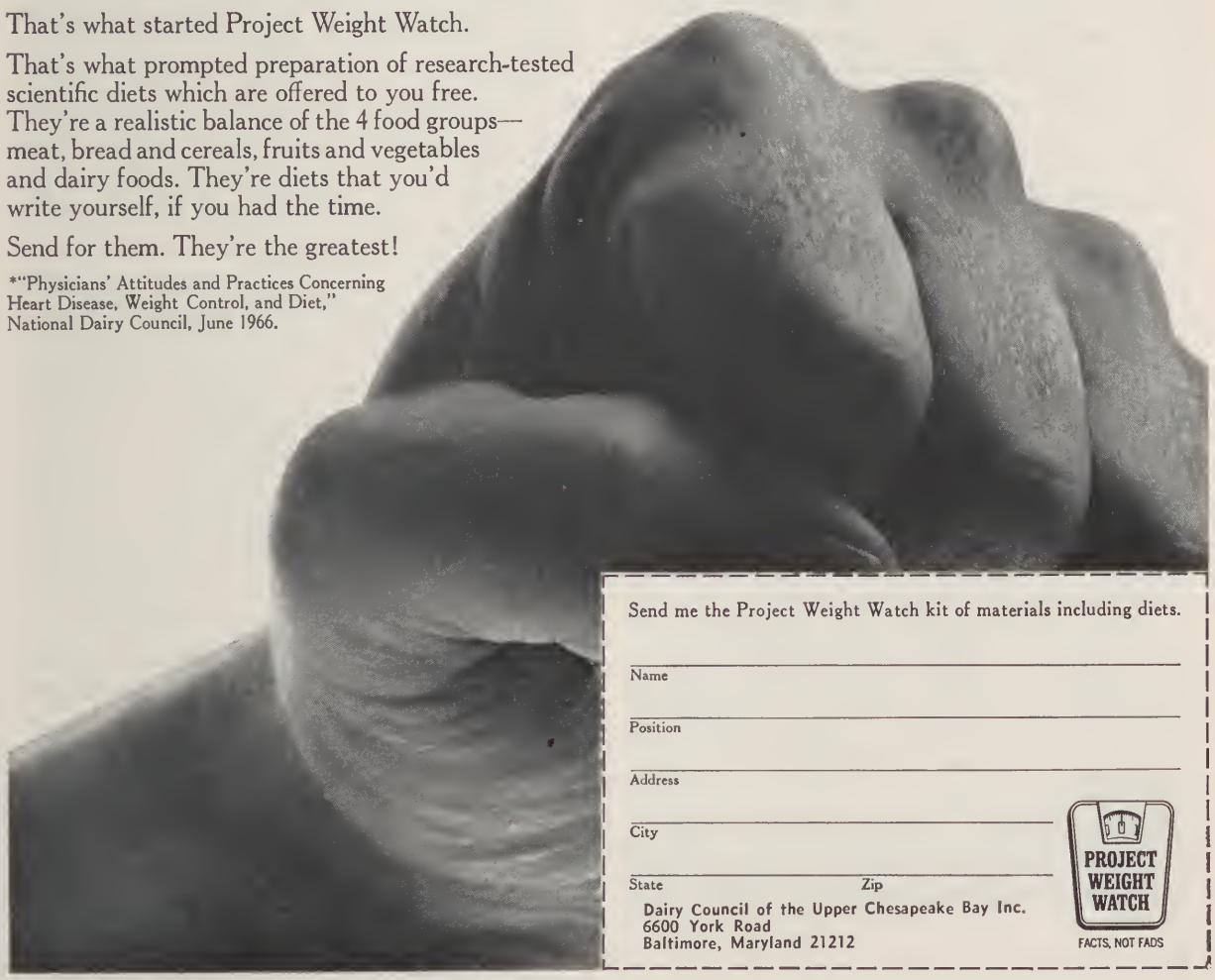
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*"Physicians' Attitudes and Practices Concerning Heart Disease, Weight Control, and Diet," National Dairy Council, June 1966.



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Alcoholism SECTION

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

Public Health Responsibility For The Alcoholic

PART I

DAVID TRACHTENBERG, MD

I am honored to be invited to speak to this first alcoholism section of the Maryland Public Health Association. The fact of the establishment of this section reflects both the increasing concern at all levels with the problem of alcoholism and our growing sense of responsibility for this very large segment of our population.

We all recognize the traditional resistance to accepting alcoholism as a medical rather than a moral problem. The assignment of moral etiology to this condition has been, and still is, the major obstacle to successful prevention and treatment, although the elements of the moral lesion seem surprisingly contradictory. We learn that alcoholism is manifested through weakness of will power, and willfullness; by *lack* of foresight, and *excessive* tendency to worry about the future, which we call *lack* of faith. We call on the alcoholic to use more will power and at the same time to surrender his willfullness to a higher power.

Frankly, it seems to me that resentment of and resistance to the disease concept of alcoholism is often sharper in the medical community than in the public at large. How often do we intone down our noses at the patient, "If you *want* to stop, why don't you just *stop*?" As a matter of fact we go even a little further. We are very likely to say to the patient, "We will treat you as soon as you stop drinking." Now you must agree that this is like saying to the pneumonia patient, "Come back for your penicillin after your fever goes away and you stop coughing." As far as I know, alcoholism is the only condition in which we demand of the patient that he cure his symptoms *before* treatment begins. Can you imagine the bewilderment of the patient who is solemnly told that we will treat him as soon as he recovers.

Now why all this resistance to the alcoholic? Why must he be cured before we will deign to help him? Is it a moral problem? We don't seem to feel the same way about syphilis or gonorrhea. We don't ask it of the homosexual nor of the compulsive thief. Why the alcoholic? After all, our goal is to help the patient, and we pride ourselves on our ability to do so. It is from this ability that we receive personal satisfaction, status in the community, and our living. Why do we change the rules when it comes to alcoholism?

Perhaps one answer is that we change the rules on the alcoholic because the alcoholic himself threatens to change the rules on us. When you think about it, a great implicit assumption in the practice of medicine is that we are on the patient's side. We are working with *him*, against his *disease*. In fact, our patients always represent two sides: One working with us, and one—the disease process-working against us. It is taken for

Presented by David Trachtenberg, MD, Psychiatrist, Chief of the Bureau of Alcoholism and Drug Addiction, Montgomery County Health Department on June 1, 1967 before a section of the Maryland Public Health Association.

granted that it is Mr. Smith and I against Mr. Smith's pneumonia. A "good patient" is one who presents us with a strong ally against his disease process.

Now obviously with an alcoholic, or in other disorders that affect personality and behavior, this necessary, albeit implicit, *therapeutic triangle* is obscure. A part of the essential *patient* is the enemy, instead of a foreign element like a fracture or a tumor. It begins to look like a *two*-sided struggle instead of a triangle, with the doctor versus the patient. We are, as we all recognize, helpless in a two-sided struggle, and, in addition, it is somewhat annoying to be treated by the patient as an enemy instead of as an honored or at least, respected helper. It makes us angry to watch the patient thwarting our good intentions, and unmoved by our consummate skill.

If we are to be of help to the alcoholic, we must remember that the triangular configuration always exists, even when one part of it seems invisible. We must seek out our ally in the patient, strengthen it, and re-establish a working triangle so that the doctor-patient alliance versus the illness becomes operative. All this can be summarized in the phrase "motivating the patient." We must force ourselves to be constantly aware that latent motivation exists within the alcoholic. If we can't reach him at any particular time, that is *our* problem. It is we who fail the patient we are unable to motivate, not he us. This is crucially important, because the difference between an operating triangle and a latent triangle is truly the difference between a good patient with a disease, and a drunk. It is our job to make that triangle operative. Later on we will talk about how we might go about achieving this.

It is my conviction that we have compelling *professional* and *ethical* reasons to undertake in the treatment of alcoholics and to exert our utmost efforts toward prevention of this grave disease—which has long since reached epidemic proportions in all of our communities. There are also a number of practical reasons. Now, what are some of the practical reasons? Before we go on to discuss them, it might we well to define the term alcoholic.

Alcoholism may be considered from the point of view of the toxic effects of the *chemical*, alcohol, and its related nutritional disturbances; it may be seen as a *symptom* of an underlying psychological or social maladjustment or disease; or, thirdly, as an *addiction* or illness in itself.

The *World Health Organization* defines excessive drinking as "any form of drinking which in its extent goes beyond traditional and customary dietary use or ordinary compliance with the social drinking customs of the whole community concerned." It goes on to state that "alcoholics are those excessive drinkers whose dependence upon alcohol has attained such a degree that it shows a noticeable mental distrubance or an interference with their bodily and mental health, their smooth social and economic functioning; or who show the prodromal signs of such development." The *World Health Organization* Subcommittee on Alcoholism has distinguished two categories of alcoholics, namely the "alcohol addict" and the "habitual symptomatic excessive drinker." In both groups the *excessive drinking* is symptomatic of underlying psychological or social pathology, but in the alcoholic group, after several years of excessive drinking, loss of control over the alcohol intake occurs. The *World Health Organization* means by "loss of control" that as soon as any small quantity of alcohol enters the body a demand for more alcohol is set up which lasts until the drinker is too intoxicated or too sick to ingest more alcohol. This "loss of control" is not responsible for initiating the drinking but becomes operant after the first drink has been taken.

In our program in Montgomery County we find that most commonly an alcoholic is considered to be someone who drinks more than his doctor. This, no doubt, is a useful concept, but we have tried to substitute for it in our program the notion that for screening purposes an alcoholic is someone who someone else *thinks* is an alcoholic. This very broad definition assists us in case finding, allows us to do our own screening, and occasionally permits us the pleasure of reassuring an abstinent wife that her husband's two beers on a Saturday night does not really indicate pathologic dependence.

We estimate that there are some 6 million alcoholics in the United States of whom probably 90,000 live in Maryland. This awesome number becomes all the more frightening when we consider that for every alcoholic, at least three family

members are involved in the overall psychological and social deterioration that ensues.

We are well aware of the tremendous drain on community resources created by deteriorating families. A study conducted in Boston and reported recently in the *New England Journal of Medicine* demonstrated over three generations that families of alcoholics not only make heavy use of public resources but raise children who also tend to be alcoholic, and whose families in turn depend on public resources. While I am aware of no good evidence that alcoholism is genetically hereditary it most certainly is passed down through families. In the general population, one of fifteen drinkers will become alcoholic in his drinking pattern. However, children of alcoholic parents have a one-in-four chance of developing the disease. Thus, it is clear that successful treatment of alcoholism also serves the purpose of prevention, a primary traditional responsibility of public health.

The tremendous cost of alcoholism to industry in terms of absenteeism, under-production, rapid turn-over, and accident rates has spurred a number of our larger industries to establish alcoholism programs. Kemper Insurance, for example, has instituted such a program in which the supervisor is the key man. Allis-Chalmers Corporation estimates that in their own program the absentee rate has been reduced from 8 per cent to 3 per cent while the firing rate for alcoholics has been cut from 95 per cent to 8 per cent. Dupont, in their program, estimates that more than 1000 employees of their company are members of Alcoholics Anonymous. I am aware of no exception to the generalization that each company that has earnestly established an alcoholism program has found it eminently useful and profitable to business. While industry has itself taken the lead in setting up industrial programs, think of how much more they could do with moral and professional support and leadership of public health agencies.

For the *TB*-minded, I might mention that in Montgomery County last year we estimated that 30% of active *TB* cases were found in our alcoholic population. And for those concerned with traffic deaths, another *New England Journal* study done in Berkeley, California concluded that while in younger people social drinking appeared to present more of a problem, "it is believed that the majority of drivers and pedestrians involved in traffic accidents after drinking are not social drinkers." One could, go on and on citing evidence to support the magnitude of this problem, which requires, it seems to me, a public health approach.

The alcoholic himself

So far we have discussed one element in the resistance to treating alcoholics, defined alcoholism, and said a few words about the size of the problem. But who are our alcoholics?

We find that alcoholism is equally distributed through all social levels. In one study 69% of the alcoholic population were found to be married and living with their wives. More than 80% were under 50 years of age and 25% were less than 35 years old. Three out of four were living in an established household and nine out of ten had lived in their present town for at least two years. Known to have steady employment on one job for at least three years accounted for 65%, and 25% for at least ten years. Seven out of ten had held jobs involving skill or special responsibilities. Indeed, the popular stereotype of the "gutter drunk" represents only eight per cent of the total alcoholic population. This does not sound like a group unworthy of rehabilitation, nor like a transient, subterranean population irrelevant to the total health of the community.

Present methods of treatment

How are we handling the alcoholic today? The first thing we do with the alcoholic is ignore him until he is forcibly brought to our attention in the later stages of his disease, through the courts, through welfare agencies, or through the schools who pick up problems in the children.

The great preponderance of inpatient treatment for alcoholics is conducted in our jails. Disadvantages to this mode of therapy are: (1) that as far as I know it does not benefit the alcoholics; (2) some alcoholics die in the jails, as do some people who are picked up and thought to be alcoholics when they are really suffering from diabetic coma or some other condition that clouds their mental state; (3) while it is useful to have alcoholics in jail, since they do a good deal of the maintenance work, they seem to keep coming back and the proverbial revolving door is the standard state of affairs. In addition, of course, the stigma of a police record hampers any subsequent efforts

at rehabilitation and employment and justifiably embitters the alcoholic in his attitude toward society. In my opinion, what we succeed in doing with jail therapy is to more firmly establish the disease in the individual, cripple his efforts at rehabilitation, and increase the drain on public resources.

State hospital programs

All of our regional State hospitals have alcoholism programs. They are overcrowded and understaffed. I am told by Dr. Kurt Gorwitz, Chief of Mental Health Statistics, that in some months admissions of alcoholics to State hospitals have approached 70% of total admissions, but at Springfield State Hospital, the one with which I am most familiar, a virtual skeleton staff is working heroically with overwhelming numbers of patients who, while afforded an opportunity to dry out, and an introduction to *AA, receive* precious little else in the way of treatment.

It is said, of course, that most of these people are really unmotivated for treatment and that this is the best we can do. However, in Montgomery County we have found that this is not so. We now send a social worker and a public health nurse to visit our patients at Springfield Alcoholic Unit, and find that patients' awareness of our presence and our interest has resulted in a sharp increase in the number of successful clinic referrals from Springfield.

Most of these people want help. Even those that don't want it now, we find, often decide that they need it a few months or a year from now. At Springfield there are no facilities for women in the Alcoholic Rehabilitation Unit, and alcoholic women are admitted and maintained on the general psychotic wards of the hospital. Even the minimal kinds of treatment afforded the male alcoholics are *denied* to the females. I want to emphasize again, the staff at Springfield is excellent, highly motivated, and overworked. They are doing their best with completely inadequate staffing and facilities.

While it is clear that the state hospitals' services to alcoholics must be greatly improved, I do not believe that the best treatment approach to alcoholism lies in the state hospital. We know that by the time an alcoholic comes to the state hospital, he is far advanced in his disease. Perhaps more important than the drinking itself is the serious *social* disorganization which now affects him and his family, giving rise to a whole new level of problems.

If effective rehabilitation is to occur, the treatment site must be in the local community. Since alcoholic family problems are multiple and complex, all persons active in the rehabilitation of the alcoholic must have thorough knowledge of the community and the capability to follow closely the alcoholic's progress and that of his family. The state hospital, even at best, is remote and limited. There is essentially no continuity of personnel with the local community, and effective liaison is limited both by miles and by the responsibility of the state hospital to serve patients from many local areas.

Private medicine

If state hospitals are remote, overcrowded, and understaffed, what about private medicine? In our experience most practitioners are discouraged about their ability to treat alcoholism. This is partly due to the triangle phenomenon that I mentioned at the beginning but partly it is completely realistic, in that most private physicians are unable to assemble the time, the flexibility of treatment modalities, and the breadth of community resources that are required to rehabilitate the majority of our middle or late stage alcoholics.

In addition, there is a lack of hard knowledge, still, in the medical community, about the treatment of the *sober* alcoholic. All of us were trained in medical school to detoxify alcoholics. But how much training was there in the treatment of the sober alcoholic, of the alcoho*lism* itself, as opposed to acute intoxication, or the medical complications of vitamin deficiency, or poisoning? I went to a good medical school and I'm sure somebody must have mentioned this treatment at one time or another, but for the life of me I can't remember when or who. As a matter of fact, in my training the only alcoholics I saw seemed to be at three o'clock in the morning in the emergency room. By the time I was through with my internship there was nobody who despised alcoholics more than I did. Those patients that I treated for acute alcoholism at that stage had a right to consider me, for all practical purposes, their enemy rather than their ally.

General hospital

The last resource existing in the community at the present time is, of course, the general hospital. In Montgomery County at least we so far, have been totally unsuccessful in persuading general hospitals to admit alcoholics as such, although we have been told that approximately 15% of their actual admissions suffer primarily with alcoholism. Whether this is true in all communities or not, I don't know, but from the literature I gather that this is a problem that affects most general hospitals. It seems to me actually criminal for a general hospital to be able to refuse admission to a group of people who are in need of help and who, it has been repeatedly demonstrated, only rarely present any problems of management or offer any unusual drain on hospital resources. In fact, in my experience, those cases in which alcoholics do present problems in control are precisely those in which the patient was admitted under a false diagnosis, so that nursing personnel and others were unable to recognize early the problems that developed, such as seizures or delirium tremens.

I have not mentioned those hospitals which specialize in treating alcoholics because they are so few and so limited in those whom they can treat. Blue Cross, for example, usually does not pay for treatment of an alcoholic in a private facility. These hospitals are further limited by their isolation from general hospitals and thus are unable to pick up cases early or to consult on the general hospital wards.

Given this woefully inadequate treatment situation, it is no wonder that we aren't helping most alcoholics and it is no wonder that they resent us and don't trust us. But *we* have no right to be discouraged. *We* have no right to be pessimistic. *We* have no right even to an opinion about the effectiveness of treatment of alcoholics. We are entitled mostly to be *ashamed* of our lack of progress so far. We are *obliged* to develop programs for the treatment of alcoholics with an open mind and with full recognition of the immense size and crucial importance of alcoholism as a national disease. I remember as a child being deeply moved by posters showing little children with polio. I wonder if we shouldn't put up posters about these same little children trying to survive in a home ravaged by alcoholic parents.

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Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

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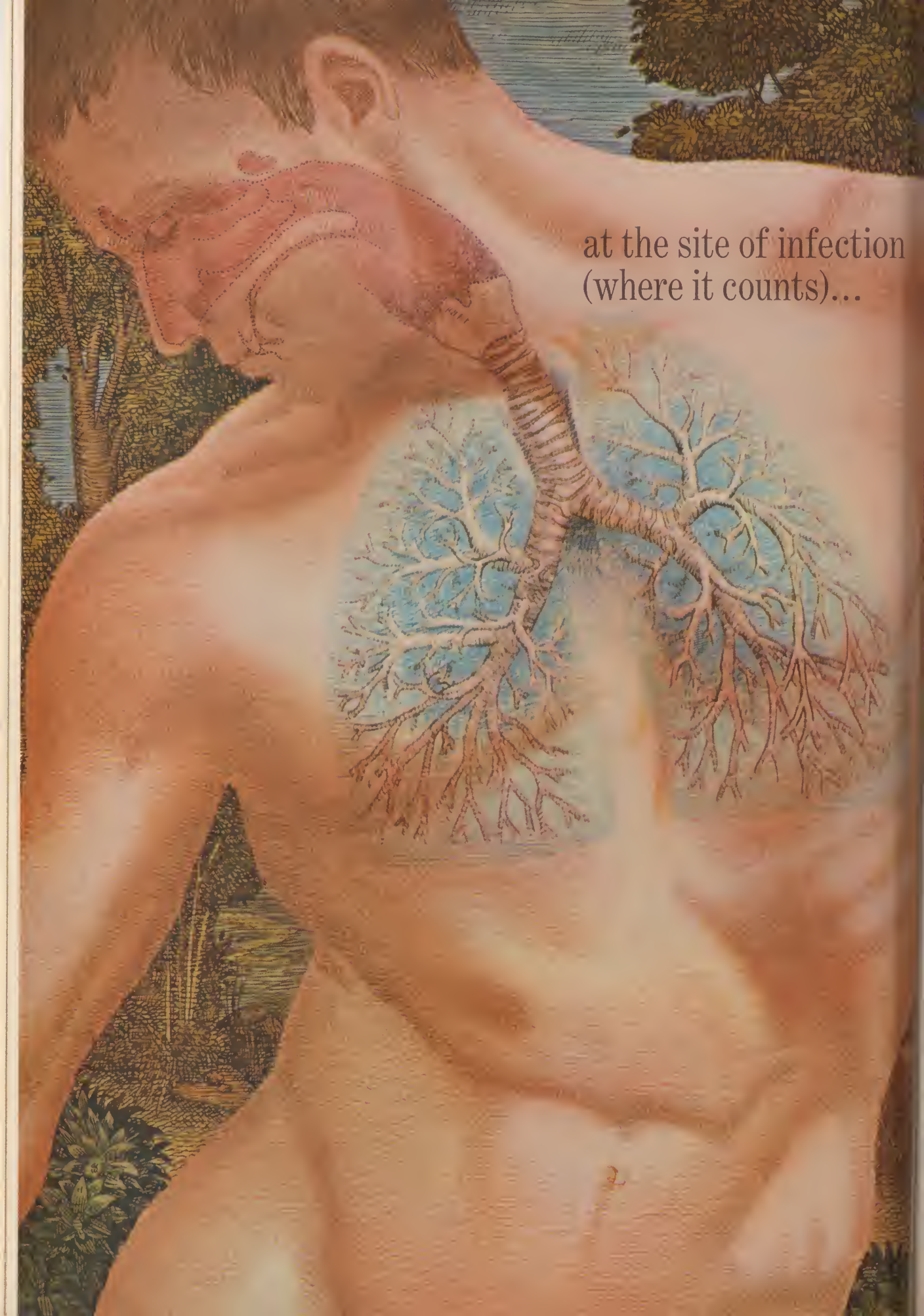
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Please see adjoining page for brief prescribing summary.

TA-5094PC

Sperling, I.L.: Applied Therap. 6:117, 1964
Rosenbaum, E.E., and Schwarz, G.R.: Northwest Med. 61:927, 1962.


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In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have also been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Adverse Reactions: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have developed in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly, usually within forty-eight hours, if the drug is readministered to sensitive patients. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appeared to be definitely related to use of the drug, laboratory findings were characterized by increased direct-reacting bilirubin, elevated alkaline phosphatase levels, negative or weakly positive cephalin flocculation and thymol turbidity tests, elevated serum glutamic oxalacetic transaminase levels, peripheral eosinophilia, and normal cholecystograms.

Individual idiosyncrasy seems evident since jaundice has not been reported in other patients taking prolonged courses of the medication. Patients with chronic infection have been given 1 to 2 Gm. of the drug daily for periods of two to six months, and patients with rheumatic fever have taken prophylactic doses of 0.5 Gm. daily for two years without difficulty. In one group of 144 patients who received the drug daily for two years, no jaundice was noted. It was of interest that members of six of these patients' families, who were not taking the drug, had episodes of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels were determined in a group of fifty-four adults and children who took 250 mg. of Ilosone daily for an average of sixteen months as rheumatic fever prophylaxis. The results were compared with those of a similar group of forty-four patients who received penicillin. There were no cases of jaundice in either group. Elevation of SGPT and serum alkaline phosphatase levels during the course of treatment was observed in one patient treated with Ilosone and in two patients treated with penicillin. Seven other patients in the group receiving Ilosone and four others in the penicillin group showed elevations in one of the tests at some time during administration of the drugs.

Very satisfactory therapeutic results, without toxicity, were reported in 102 pediatric patients who received short-term (ten day) courses of Ilosone in the treatment of streptococcus infections. Results of liver function tests in these patients were comparable to those in a similar control group who had received penicillin.

Gastro-intestinal disturbances not associated with hepatic effects are observed in a small proportion of individuals as a result of a local stimulating effect of the medication on the alimentary tract; however, the normal intestinal gram-negative bacterial flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with the use of erythromycin, there have been occasional reports of urticaria, skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orally.

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For infants and for children under twenty-five pounds of body weight, the usual dosage is 5 mg. per pound every six hours; for children twenty-five to fifty pounds, 125 mg. every six hours. (Tablets Ilosone Chewable should be chewed or crushed and swallowed with water.)

For adults and for children over fifty pounds, the usual dosage of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythromycin therapy should be considered.

In the treatment of syphilis, the recommended total dosage is 20 to 30 Gm. given in divided doses for a period of ten to fifteen days. Close follow-up of the patient is necessary since erythromycin drugs have not had adequate evaluation in all stages of syphilis. Examinations of spinal fluid are recommended as part of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four days is recommended. In the treatment of gonorrhea, patients with suspected lesion of syphilis should have a dark-field examination before receiving antibiotics, and monthly serologic tests should be made for a period of three months.

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Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equivalent to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size packages.

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 10-cc. packages, with dropper calibrated at 25 and 50 mg.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to base) in bottles of 50. [032

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:69, 2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:398. 3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 1960.

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DEPARTMENT OF HEALTH
STATE OF MARYLAND
William J. Peeples, MD, MPH, Commissioner

Highlights

CANCER CYTOLOGY FIGURES AVAILABLE

In the 1966 calendar year, 377,809 cytologic examinations for the detection of cancer were performed in laboratories throughout the State; 120,772 in hospital laboratories, 212,169 in private laboratories, and 44,868 in Health Department laboratories. The vast majority of these were Papanicolaou smears for detection of cancer of the cervix. The total excludes research studies such as the self-administered irrigation pipette tests. The figures are available for the first time as the result of the 1966 law regulating clinical laboratories.

SYPHILIS TESTING CENTRALIZED

The syphilis serology testing of some 60,000 specimens formerly examined each year by the Baltimore City Branch Laboratory was recently consolidated in Central Laboratory. This centralization will improve the efficiency and uniformity of this diagnostic test and will increase the speed of reporting to physicians.

DR. STIFLER TO HEAD MEDICAL CARE SERVICES

Jean Rose Stifler, MD, has been named to the post of Assistant Commissioner of Medical Care Services, in charge of administering three Bureaus: Preventive Medical Services (headed by Dr. Stifler since July, 1965), Chronic Diseases, and Special Health Services. Dr. Stifler has served as Chief of the Division of Crippled Children's Services since 1954.

Miriam S. Van Gelder, MD, Acting Chief of the Inpatient and Outpatient Sections of the Division of Medical Services, is acting as Director of the Bureau of Special Health Services, a post left vacant by the death of Claude C. Dodson, MD, in May.

SINGLE FEE FOR PHARMACISTS SET

Regulations governing payments to pharmacists under the Medical Assistance Program have been amended to provide that a single fee of $1.50 be paid for filling any prescription, rather than the former $1 and $2 fees based on cost of the item.

MINERS HOSPITAL EQUIPPED FOR DISASTER

Miners Hospital in Frostburg has contracted through the Division of Emergency Health Services for emergency medical supplies which will assure the hospital sufficient material for 30 days of casualty care in the event of a disaster which might disrupt supply lines. To avoid deterioration, the hospital will rotate the supplies with materials used in daily operations, replacing items as needed.

The emergency supplies are furnished by the US Public Health Service, which plans to establish similar stockpiles at selected hospitals throughout the nation. The first in Maryland, Miners Hospital was chosen because it has met all Federal and State criteria for emergency planning, including community service capability and location.

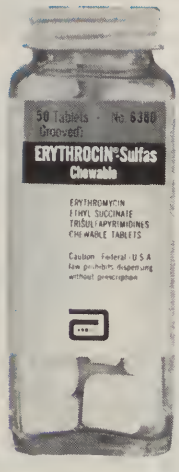
VISION-SCREENING TECHNICS TO BE TAUGHT

In cooperation with the Department of Education, a five-day in-service training program to review vision and hearing screening technics will



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In clinical trials[1,2], this orange-flavored tablet was given to 55 patients, aged four months to 18 years.

Diagnoses (multiple in some cases) represented a cross section of bacterial infections commonly seen in pediatric office practice.

Therapy was given from three to 12 days, with an average of six days.

Of the 55 patients, 30 were reported cured within 72 hours, while 22 showed partial recovery within the same time, and subsequent clinical cure.

A clinical cure rate of 94.5%

ERYTHROCIN®-SULFAS Granules (Erythromycin ethyl succinate-trisulfapyrimidines granules for oral suspension)

87 patients were treated[1,2]—all children, ages four months to 15 years.

The diagnoses were multiple in some cases and were chiefly bacterial infections of the respiratory tract.

Dosage was maintained from three to 10 days; average treatment was five days. All of the ill children accepted the orange-flavored suspension favorably.

53 were clinically cured within 72 hours, while 32 showed partial relief within the same time, and subsequent clinical cure.

701358

A clinical cure rate of 97.7%

1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

ABBOTT

Brief Summary on next page

ERYTHROCIN®-SULFAS
Brief Summary

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or newborn infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. of each of sulfadiazine, sulfamerazine and sulfamethazine.



701358

be offered in September in three locations —Frederick, Cheverly, and Salisbury. Three and one-half days will be devoted to technics of hearing screening, and one and one-half days to detection of possible visual disorders. Purpose of the program is to expand the training of supportive personnel.

FILM DESCRIBES VENEREAL DISEASE FOLLOW-UP

A 15-minute film, "Syphilis Epidemiology Interview," describes the epidemiologist's role in tracing sources of infection when a case of syphilis is reported to the Health Department. The important assurances of discretion and confidentiality are stressed in the film, which is recommended to medical societies, hospital staffs, and professional nurses. It is available for loan from the State Health Department.

DIAGNOSTIC AND ADVISORY SERVICE EXPANDS

The diagnostic and advisory services for handicapped children have been augmented by the establishment of another team consisting of a pediatrician, psychologist, public health nurse consultant, and a part-time social worker. These teams travel from Baltimore to the counties of Maryland where children with complex problems are evaluated. The additional team should permit more frequent visits to the eight counties now being served and the extension of this specialized service to other areas largely isolated from existing diagnostic and evaluation facilities.

RUBELLA REGISTRY PLANS GO FORWARD

The *Medical and Chirurgical Faculty* has circulated a letter to member physicians urging their cooperation in the rubella registry project, which seeks to locate children suffering from birth defects as a result of the rubella epidemics of 1963-64. It is now believed that the incidence of the rubella syndrome may be much higher than previously estimated, auguring serious overtaxing of the State's remedial and educational facilities a few years hence.

In studies performed on children with confirmed congenital rubella, less than 5 per cent had no detectable abnormality. Thirty-five per cent had cardiac disease; 50 per cent had hearing problems, half of these profound; 20 per cent had



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visual problems, two-thirds of them severe; 54 per cent were retarded in development, half of these severely; and 60 per cent had small head size, many of these also showing poor growth and failure to thrive.

The Bureau of Preventive Medical Services and the office of Community Health Services are preparing materials to aid physicians and parents in locating and identifying the rubella-damaged child, and describing the services available to help meet the child's needs prior to reaching school age.

ANNUAL MEETING CRUISE CONVENTION

MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

SAN JUAN and *ST. THOMAS* CRUISE CONVENTION, April 21 to 28, 1968

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Thurs., April 25th—Sail from San Juan at 3:00 AM and arrive in St. Thomas at 9:00 AM — sightseeing tours will again be offered to see this charming island. Sail from St. Thomas about 4:00 PM.

Sun., April 28th— Arrive Baltimore in the afternoon about 2:00 PM.
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BALTIMORE CITY

Board of Directors Meeting

Seven of the members of the Board of Directors of the Baltimore City Medical Society were present for the Board of Directors meeting on June 13, 1967 at 4:30 P.M. at 1211 Cathedral Street, Baltimore, Maryland. Russell Fisher, MD, presided in the absence of Harold J. Connolly, MD. A letter was read from John B. De Hoff, MD, Director of the Local Health Services, sent to Mr. John Sargeant, Executive Secretary of the Medical and Chirurgical Faculty of the State of Maryland. Dr. De Hoff explained, that in December of 1966, James Wharton, MD, Chief, Community Health Services, U.S. Public Health Services, met with representatives of the School of Hygiene and the City Health Department concerning a study for the application of cost-benefit analysis to health planning. Such a program designed to study the solo-private practice of medicine in the local community was described. The Board decided that their support in cooperation for such a study would be given after the complete details of such a program were designed by the Public Health Service. Further, the Public Health Service was invited to come to the Board of Directors prepared to discuss in detail this project.

R. C. V. Robinson, MD, Chairman of the Professional Relations Committee, presented five cases to the Board for recommendations and course of management. These problems were dealt with in accordance with the complaint. Several members of the society eligible for Emeritus membership were discussed. The following members were approved for a membership in the Baltimore City Medical Society: Samuel S. Frankel, MD, B. MacGowan, MD, Col. Arthur N. Tasker, Helen I. Maginnis, Alexis M. Gagusin, and E. Ross Davies.

John W. Pearson, MD, Anesthesiology and member of the Baltimore City Medical Society since 1961, announced he was going on a teaching leave to Okinawa for two years. It was the Board's opinion that he should be classified as a member on leave, thus preserving his membership.

W. Mintzer, MD, Director of the Measles Vaccination Campaign for the Baltimore City Medical Society, reported that 14,424 patients had been immunized during the recent program sponsored by the Society. The meeting was adjourned at 6:20 P.M.

Arthur E. Cocco, MD
Baltimore City Medical Society

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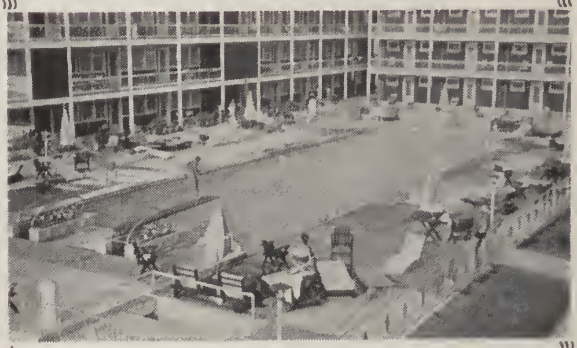
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References: 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rawls, W., et al.: Med. Times, 87:818, 1959.

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RIDAY AND SATURDAY
SEPTEMBER 8 & 9
1967

DIPLOMAT MOTOR HOTEL
REGISTRATION

Lobby

THURSDAY, SEPTEMBER 7
4:00 P.M. to 9:00 P.M.

FRIDAY, SEPTEMBER 8
9:00 A.M. to 5:00 P.M.

SATURDAY, SEPTEMBER 9
9:00 A.M. to 11:00 A.M.

ALL MEMBERS AND GUESTS
ARE REQUESTED TO REGISTER

NO REGISTRATION FEE

COUNCIL MEETING

Meeting Hall — north side of building

THURSDAY, SEPTEMBER 7
8:30 P.M.

HOUSE OF DELEGATES MEETING

Meeting Hall — north side of building

FRIDAY, SEPTEMBER 8
9:30 A.M.

ALL members of the Faculty are invited to attend the meeting of the House of Delegates.

OFFICERS

Richard D. Bauer, M.D., *President*
William A. Pillsbury, M.D., *Secretary*
Karl F. Mech, M.D., *Treasurer*

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Friday, September 8

POOLSIDE COCKTAIL PARTY
Hors d'oeuvres and entertainment
6:30 P.M.

BANQUET
7:30 P.M.

Amos R. Koontz Memorial Lecture
CONGRESSMAN EUGENE J. KEOGH*

Congressman Keogh of New York is the author of R-10, the Self-Employed Retirement Act, and has just tired after thirty years in the U.S. Congress. Mr. ogh has a message of pertinent interest to physicians d their families. He has spoken at numerous medical eetings throughout the country where he has been thusiastically received and those attending felt it a ost rewarding session.

There will be a *question and answer period* following r. Keogh's talk.

PHILLIPS CRAB HOUSE
Saturday, September 9

CRAB FEAST LUNCHEON
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WOMAN'S AUXILIARY MEETING
Dining Room
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9:30 A.M. Coffee and Buns
10:00 A.M. Business Meeting
11:00 A.M. Speaker — To Be Announced

Everyone invited

1:00 P.M. to 4:00 P.M. **MARYLAND ASSOCIATION OF NURSING HOME PHYSICIANS**
Luncheon Meeting — Dining Room
THE NURSING HOME PHYSICIAN: HIS CHANGING ROLE

1:30 P.M. to 4:00 P.M. **MARYLAND OPHTHALMOLOGICAL SOCIETY**
Meeting Hall — north side of building

METASTATIC OCULAR TUMORS
Derek J. Sharvelle, M.D.

SIMULTANEOUS OCCLUSION OF CENTRAL RETINAL ARTERY AND VEIN
Leeds E. Katzen, M.D.

TECHNIQUES OF MUSCLE SURGERY
James L. Laubach, M.D.

CONTACT LENS FITTING IN INFANTS
Blackwell S. Bruner, M.D.

VISUAL PROGNOSIS AND LONGEVITY IN DIABETES MELLITUS
Joseph W. Berkow, M.D.

BLOWOUT FRACTURES OF THE ORBIT
Thomas R. O'Rourke, Jr., M.D.

LEGISLATION OF IMPORTANCE TO MARYLAND OPHTHALMOLOGISTS: PAST, PRESENT AND FUTURE
Abraham Kremen, M.D.

2:00 P.M. to 3:30 P.M. **MARYLAND SOCIETY FOR THE RHEUMATIC DISEASES**
Meeting Hall — north side of building

SYMPOSIUM ON THE DIAGNOSIS AND MANAGEMENT OF GOUT
A. Lewis Kolodny, M.D.
Alexander S. Townes, M.D.
K. A. Peter van Berkum, M.D.

ALL PHYSICIANS INVITED TO ABOVE MEETINGS

DIPLOMAT MOTOR HOTEL
SATURDAY, SEPTEMBER 9

8:30 A.M. to 11:30 A.M. **MARYLAND CHAPTER, AMERICAN COLLEGE OF SURGEONS**

Meeting Hall — north side of building

REGISTRATION

PRACTICAL CONSIDERATIONS IN THE USE OF CHEMOTHERAPY AND RADIATION FOR MALIGNANCY

A panel discussion based on case presentations designed to give the practitioner a comprehensive picture of current thinking in this area.

Moderator:

R. Robinson Baker, M.D.

Panelists:

Everard F. Cox, M.D.
Conrad G. Julian, M.D.
Albert H. Owens, Jr., M.D.
Norman Tarr, M.D.
Morris J. Wizenberg, M.D.

COFFEE

10:00 A.M. to 11:00 A.M. **MARYLAND DIABETES ASSOCIATION**

Dining Room

GROWTH HORMONE AND DIABETES MELLITUS

Milton S. Grossman, M.D.

11:00 A.M. to 12 noon **MARYLAND PSYCHIATRIC SOCIETY**

Dining Room

THE PSYCHIATRIC-SURGICAL APPROACH TO ADOLESCENT DISTURBANCE IN SELF IMAGE

Norman J. Knorr, M.D.
John E. Hoopes, M.D.
— discussant

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MEDICAL and CHIRURGICAL FACULTY of MD.

DIPLOMAT MOTOR HOTEL

BUSINESS MEETINGS of SPECIALTY SOCIETIES

FRIDAY, SEPTEMBER 8

3:00 P.M. to 4:00 P.M. Joint Meeting of the Maryland Diabetes Association and the Subcommittee on Diabetes of the Medical and Chirurgical Faculty
Lobby — second floor

4:00 P.M. to 4:30 P.M. Maryland Ophthalmological Society Meeting
Meeting Hall

5:00 P.M. to 6:00 P.M. Maryland Chapter, American College of Surgeons — Meeting of Executive Council
Lobby — third floor

SATURDAY, SEPTEMBER 9

9:00 A.M. to 10:00 A.M. Maryland Society of Pathologists — Council Meeting
Lobby — second floor

10:00 A.M. to 11:00 A.M. Maryland Academy of General Practice — Meeting of Board of Directors
Lobby — third floor

11:30 A.M. to 1:00 P.M. Maryland Chapter, American College of Surgeons — General Business Meeting
Meeting Hall

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Recently Modell[2] has stated: "The mercurial diuretics are the injectable diuretics of choice since they are the most potent as well as the most dependable. Their toxicity is not an important consideration either by comparison with other potent diuretics or in relation to the seriousness of the conditions in which they provide such excellent relief."

IN BRIEF

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1. Gold, Harry, *et al.: A System for the Routine Treatment of the Failing Heart,* The American Journal of Medicine, Vol. III, No. 6:665-692 (Dec.) 1956.

2. Modell, Walter: *Drugs of Choice 1966-1967*, p. 97, 1966.

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the HEART PAGE
A Service of The Heart Association of Maryland
Chris Papadopoulos, MD—*Editor*

Current Surgical Treatment of Congenital Heart Disease in Infants

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Division of Thoracic Surgery,
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Congenital heart disease is a common cause of death in children. Each year in the United States approximately 7,000 children die from such defects, the majority in the first four months of life. If one is to salvage these children, a vigorous approach to this problem must be undertaken making early diagnosis and early operative intervention mandatory. This report demonstrates the advantage of such an aggressive approach.

During an 18-month period encompassing March, 1965 to October, 1966, 21 infants and small children with congenital heart disease were operated upon at the University of Maryland Hospital (Table 1). Except for one ten-pound child of 2 years of age, all of these children were less than four months old when originally operated upon and ranged in weight from 4.75 to 10.7 pounds. Only one child was a product of a premature birth and thirteen were cyanotic.

This group of children were afflicted with a wide variety of cyanotic and acyanotic lesions. In each instance, operative intervention was carried out as a life-saving procedure. The operative procedure was varied for the particular lesion and while curative in six patients, was generally of a palliative nature. Fourteen of these children survived.

Joseph S. McLaughlin MD, is a John and Mary R. Markle Scholar in Academic Medicine.

Tetrology of Fallot

This abnormality is the most common cause of cyanotic heart disease and is characterized by a ventricular septal defect and pulmonary stenosis often of the infundibular or muscular variety. This anatomical combination produces a shunt of the blood from the right to the left ventricle, bypassing the lungs and results in arterial desaturation. The severe hypoxia clinically manifests itself by cyanosis of the tissues, squatting in older children and hypoxic "spells." The latter episodes are characterized by an increase in intensity of the cyanosis, unresponsiveness, inability to feed and bradycardia. Although heart failure in the usual sense is not common in these children, death from hypoxia frequently occurs at an early age often at the time of closure of the ductus arteriosus.

Surgical intervention is directed toward increasing pulmonary blood flow and is accomplished by creating a shunt between the systemic and the pulmonary arterial circulations. The classic operative procedures of Blalock (subclavian pulmonary artery anastomosis) and Potts (aortic pulmonary artery anastomosis) are the most com-

Table 1
INFANT HEART SURGERY

DATE	NAME	AGE	DIAGNOSIS	PROCEDURE	REMARKS
4/19/65	R.A.	2 wk.	Ventricular septal defect	Pulmonary artery banding	Expired 5 days postoperation
5/10/65	D.S.	3 wk.	Patent ductus arteriosus	Ligation P.D.A.	
6/5/65	A.D.	3 mos.	A-V canal	Pulmonary artery banding	Expired in OR
6/7/65	L.F.	4 mos.	Ventricular septal defect and patent ductus	Ligation P.D.A.	
7/11/65	A.P.	4 mos.	Tetrology of Fallot	Blalock procedure	
9/23/65	V.M.	12 days	Transposition of great vessels	Pulmonary artery banding	Expired in OR
10/25/65	B.G.	3 mos.	Patent ductus arteriosus	Ligation P.D.A.	
11/9/65	G.S.	10 days	Tetrology of Fallot	Blalock procedure	
11/13/65	G.J.	2 days	Transposition of great vessels	Creation ASD	Expired 1 day postoperation
11/15/65	J.B.	2 mos.	Tetrology of Fallot	Blalock procedure	
11/17/65	A.R.	3 mos.	Vascular ring	Division vascular ring	
11/22/65	D.M.	7 days	Transposition of great vessels	Creation ASD	
7/21/66	L.E.	2 mos.	Vascular ring	Division vascular ring	
8/7/66	B.S.	5 days	Transposition of great vessels	Creation ASD	
8/15/66	M.C.	4 mos.	Patent ductus arteriosus	Ligation P.D.A.	
8/15/66	T.O.	2 yrs.	Ventricular septal defect Patent ductus arteriosus	Ligation P.D.A. and P.A. banding	
8/29/66	T.W.	4 mos.	Ventricular septal defect Patent ductus arteriosus	Ligation P.D.A. and P.A. banding	
9/6/66	A.P.	18 mos.	Tetrology of Fallot	Potts procedure	
9/20/66	R.G.	8 wk.	Primary pulmonary hypertension	None correctable	Expired in OR
9/24/66	G.K.	3 days	Pulmonary stenosis and atrial septal defect	Pulmonary valvulotomy	Expired 1 day postoperation
10/5/66	B.M.	4 mos.	Tetrology of Fallot	Cooley	Expired 1 day postoperation
10/10/66	G.C.	4 mos.	Tetrology of Fallot	Cooley	

mon methods of producing such fistulae; however, the Blalock anastomosis has the frequent disadvantage of inadequate size in the small infant and the Potts anastomosis is difficult to take down at the time of definitive repair. A recent modification of the Potts procedure, described by Cooley, in which an anastomosis is performed between the pulmonary artery and the ascending aorta, is technically simple to abolish at the time of definitive repair but again has the disadvantage of small size in these children with small pulmonary arteries.

In the presented group of patients, all three of the methods described were utilized. In the case of A.P., a Blalock procedure was originally carried out. This resulted in marked improvement, the infant was less cyanotic, gained weight and no longer experienced hypoxic spells until 15 months later, at which time the symptoms returned. Reevaluation at 18 months revealed a functioning anastomosis; but now too small to cope with the increased size and activity. For this reason, a Potts anastomosis was performed on the contralateral size. At the time of operation, the effectiveness of the previous procedure was demonstrated by a three-fold increase in size of the pulmonary artery. The child has had a gratifying response. Both procedures were effective and the child now has a chance for completely corrective procedure when he is 4 or 5 years of age.

One child in this group died. The anastomosis functioned well for some hours, but then clotted. Re-operation was unsuccessful.

Transposition of the Great Vessels

Although Tetrology of Fallot is the most common cause of cyanotic heart disease, transposition of the great vessels is the most common cause of death in infancy in children with cyanotic heart disease. It is characterized anatomically by the aorta taking origin from the right ventricle and the pulmonary artery taking origin from the left ventricle. The pulmonary and systemic circuits do not mix unless a communication such as a septal defect or a patent ductus arteriosus exists between the two circulations. Fortunately this is usually the case, but unfortunately, such additional abnormalities may compound the problem by producing increased pulmonary blood flow and heart failure.

Complete surgical repair of the lesion is now possible but cannot be carried out in the small infant. Original efforts are therefore aimed at palliating the condition until the child has gained sufficient size for definitive repair. The palliative procedure must be tailored to the individual anatomic defect and is directed at increasing mixing of the circulations where such mixing is inadequate and decreasing pulmonary blood flow where such flow is detrimental. Adequate mixing of the circulations can be accomplished by creating an atrial septal defect and the excessive blood flow to the lungs is decreased by constricting the pulmonary artery. In those instances where marked pulmonary stenosis exists the creation of a systemic pulmonary artery shunt is indicated.

In this group of four patients, three had inadequate mixing of the circulation and one had a ventricular septal defect and a patent ductus arteriosus with overwhelming pulmonary blood flow. In the former three patients, each less than seven days old, an atrial septal defect was produced under direct vision utilizing inflow occlusion. One of these patients died 24 hours following the operative procedure, the other two children have demonstrated marked improvement. Important in the fourth case was the child's age of twelve days. She was intensely cyanotic at birth but was vigorous, cried strongly and took feedings avidly for the first week of life. Thereafter, her clinical condition rapidly deteriorated: she was in severe heart failure at the time of admission and moribund at the time of operation. She died during the initial stages of the procedure. One may only speculate on the outcome had the child been seen at an earlier stage. In recent months the balloon catheter technique of creating atrial septal defects was utilized in our institution.[1] This procedure carried out at the time of cardiac catheterization negates the necessity of open thoracotomy. Preliminary results are encouraging.

[1] Swisher, Kyle Y. Jr., MD; Personal Communication.

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SYNOPSIS OF PEDIATRICS, by James G. Hughes, MD; The C. V. Mosby Company, St. Louis.

This second edition contains many revised texts, brand new chapters and rewritten sections. Its central purpose is to discuss the fundamentals of pediatrics in a clearcut, straightforward manner, and it does this.

PATHOLOGIC PHYSIOLOGY, Mechanisms of Disease, Fourth edition; William A. Sodeman, MD, W. B. Saunders Company, Philadelphia.

Because of the ever increasing pace at which medical science is advancing, the editors and contributors to this fourth edition were confronted with the task of sorting and interrelating this mass of newer knowledge in a meaningful way. In every chapter an attempt has been made to reach deeper into subcellular mechanisms to promote a greater understanding of how and why symptoms appear. This new edition is a worthwhile book for every physician's library.

HANDBOOK OF ORTHOPEDIC SURGERY by Alfred R. Shands, Jr., MD, and R. Beverly Raney, Sr., MD; C. V. Mosby Company, Saint Louis.

Preparation of this seventh edition has involved no major rearrangements of the text, but outdated material has been deleted and new facts and new viewpoints have been added. The chapter on poliomyelitis has been sharply reduced, while new sections include avascular necrosis of the femoral head, acquired spastic paralysis in adults and traumatic paraplegia and quadriplegia. This book conveys the fundamental facts and principles of orthopedic surgery as concisely as is possible.

THE HOSPITALIZED CHILD AND HIS FAMILY, Johns Hopkins Press, by J. Alex Haller, Jr., MD.

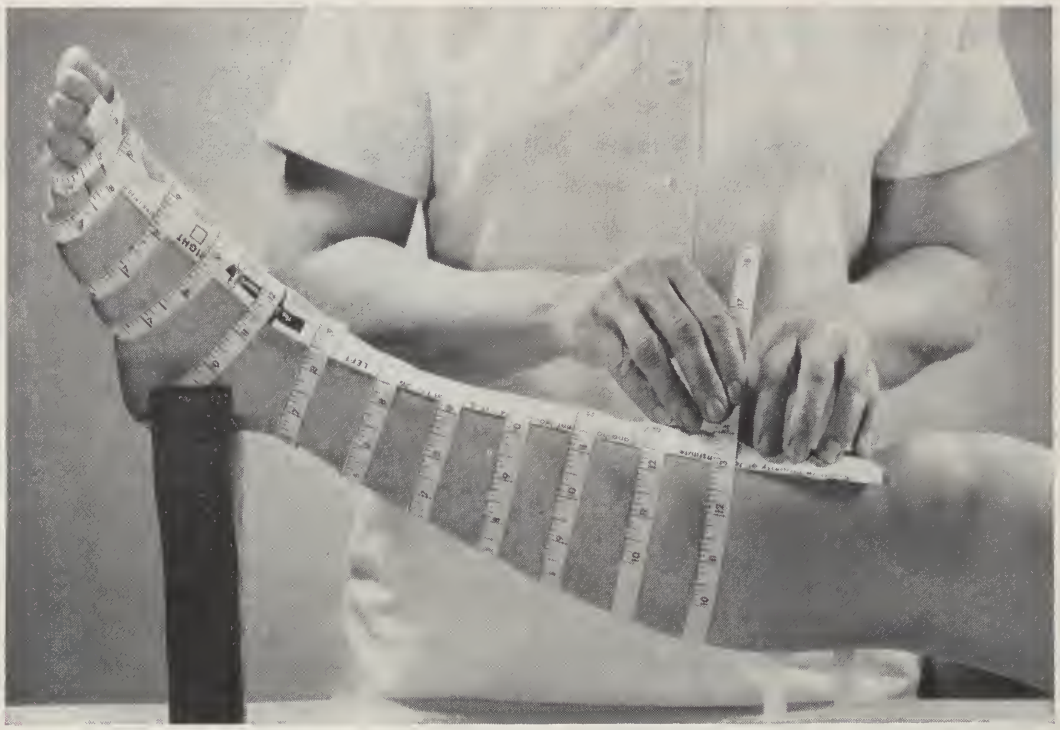
This book is composed of six essays in terms understandable to parents and yet technically accurate enough to stimulate nurses, paramedical personnel and physicians in training. Many of the concepts are not original, but their correlation and personal interpretation by a group of concerned physicians are unique, it is believed. Divided into six distinct sections, this book is worthwhile for the physician to have and loan out to parents. This type of communication is one that is sorely needed and often forgotten in the rush of the busy practitioner's life.

PATHOLOGY by Stanley L. Robbins, MD, W. B. Saunders Company, Philadelphia.

The third edition of this book proves the need for a presentation of pathology specifically designed and written for students and clinicians. Particular attention is given to the pathogenesis of disease and to the clinical correlations. New illustrations have been added, many depicting ultrastructural change in recognition of the transition now occurring in the morphologic study of disease. Owners of this publication will have imparted to them a sound knowledge of pathology, providing at the same time a not unpleasant means of gaining such knowledge.

TEXTBOOK OF MEDICINE, Twelfth Edition, by Paul B. Beeson, MD, and Walsh McDermott, MD, W. B. Saunders Company, Philadelphia.

This twelfth edition, exactly 40 years after the first one, demonstrates how very different are the two worlds into which these two editions were born. This book has become a standard for reference purposes throughout the world and the new edition only serves to point up this purpose. Over 200 of the articles contained in it are newly written; and 57 subjects are included that were not in the last edition. Every medical library of any note must have this textbook to round out its collection.



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Woman's Auxiliary
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AUGUST, 1967

Round-up Report

Atlantic City 1967

A visit from two Vietnamese students, a talk by a noted proponent of sex education and a "Little Workshop" for state presidents and presidents-elect were outstanding features of the 44th annual convention of the Woman's Auxiliary to the American Medical Association. The meeting, held at Atlantic City's Shelburne Hotel, June 18-22, attracted a registration of 1,052 physicians' wives.

Auxiliary President Mrs. Asher Yaguda presided over the sessions. The Vietnamese students, both mothers of three-year-old daughters, visited the convention on Monday and were available to meet their auxiliary sponsors. The two young women were "adopted" by the auxiliary for their short-term, specialized medical training at the Georgetown University School of Medicine in Washington, D.C. Part of their living expenses for their three-month training, is being paid for by auxiliary sponsors.

Mary S. Calderone, MD, director of the Sex Information and Education Council of the United States, spoke during the Tuesday morning session



Taken at the AMA Convention, Atlantic City, N.J. were the Maryland delegation. Left to right: Mrs. Roderick M. Shipley, Mrs. Wallace H. Sadowsky, Mrs. William S. Stone (President), Mrs. James Gary (Alternate), Mrs. M. McKendree Boyer (Delegate), Mrs. Richard D. Bauer (Delegate), Mrs. Elmer G. Linhardt (Alternate), Mrs. DeWitt E. DeLawter (Delegate).

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on "Sex Education: Goals and Means." Other speakers included Anne R. Somers, Research Associate, Industrial Relations section, Princeton University; and Charles L. Hudson, MD, 1966-67 *AMA* president, who spoke on "The Women—Bless 'Em" during the annual luncheon honoring auxiliary past presidents and *AMA* officers, trustees and their wives.

* * * * *

A highlight of the convention was the "Little Workshop," a two-way discussion led by national committee chairmen on auxiliary programs.

The auxiliary's annual contribution to the *AMA* Education and Research Foundation—this year amounting to $384,649.48—was presented during the convention. Six state auxiliaries receiving awards of merit for raising the largest amounts in their membership categories were Wyoming, Maryland, West Virginia, Tennessee, Indiana and California.

Miss Margaret Wolfe, executive secretary of the Auxiliary, was made an honorary member of the organization in recognition of 25 years of service in her position.

* * * * *

Other convention highlights were the presentation of the Health Mobilization Award to the Robeson County, N.C., auxiliary for its work in training citizens in medical self-help; and a Sunday evening reception honoring Mrs. Yaguda and Mrs. Karl F. Ritter, president-elect.

Mrs. Ritter presented her inaugural address on Wednesday, June 21, following her installation as president. Present for the occasion were Milford O. Rouse, MD, newly installed *AMA* president, and Mrs. Rouse.

Other officers installed were Mrs. C. C. Long, Ozark, Ark., president-elect; Mrs. Howard Liljestrand, Honolulu, Hawaii, first vice president; Mrs. Robert F. Beckley, Eastern regional vice president; Mrs. John D. Dickie, Toledo, Ohio, North Central vice president; Mrs. R. C. L. Robertson, Houston, Texas, Southern regional vice president; Mrs. Clare W. Johnson, Phoenix, Arizona, Western regional vice president; Mrs. Erle E. Wilkinson, Nashville, Tennessee, constitutional secretary; Mrs. E. R. W. Fox, Coeur d'Alene, Idaho, treasurer; and directors, Mrs. George W. Gasser, Logan, Utah; Mrs. J. Murray Kinsman, Louisville, Kentucky; Mrs. Jost J. Michelsen, Boston, Massachusetts; Mrs. Paul E. Rauschenbach, Paterson, New Jersey; Mrs. Willard C. Scrivner, East St. Louis, Illinois, and Mrs. Herbert J. Ulrich, Buffalo, New York.

Serving their second year as directors are Mrs. Thomas Anton, Mrs. Norman H. Gardner, Mrs. Amos N. Johnson, Mrs. Burton E. Kintner, Mrs. W. A. Merritt and Mrs. Glenn T. Scott.

* * * * *

Additional convention features were:

The Monday Guest Day Luncheon for representatives of National Women's Organizations.

The Monday Family Night for auxiliary and *AMA* members, guests, children and teenagers.

Reports from state auxiliary presidents.

A political action discussion by Miss Evelyn Dubrow, legislative representative, International Ladies' Garment Workers' Union and Miss Lee Ann Elliott, assistant director, *AMPAC*.

A round-up report on the *AMA* House of Delegates activities by Ernest B. Howard, MD, *AMA* assistant executive vice president.

A report of the *AMA's* activities in home-centered health care by Roy F. Perkins, MD,

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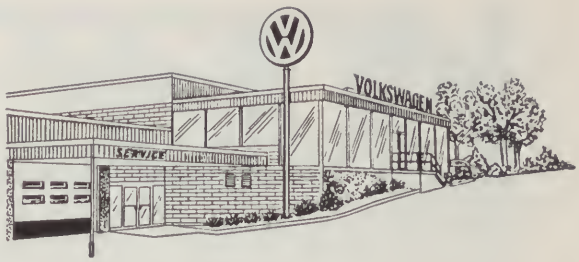
MARYLAND MEDICAL AUXILIARY RECEIVES FOUNDATION AWARD

The Woman's Auxiliary to the Medical and Chirurgical Faculty of Maryland received an award of merit for its outstanding effort in the American Medical Association Education and Research Foundation program in 1966-67. The presentation was made during the 44th Annual Convention of the Woman's Auxiliary to the AMA, held the week of June 18-22.

The Maryland Auxiliary made the greatest contribution of any state group in the 501-1000 member category—$5,564.

The entire national Auxiliary contribution was $384,649, part of which will be given to medical schools for unrestricted use. The remainder will go to the student loan guarantee fund. This fund makes possible long-term bank loans to medical students, interns and residents, with no payment due on either principal or interest until five months after completion of all training. For each $100 contributed, $1,250 in loans is made available.

1966-67 Auxiliary president was Mrs. Archie R. Cohen, Clear Spring. Mrs. G. O. Himmelwright, Cumberland, served as AMA-ERF chairman, and Mrs. Wallace H. Sadowsky, Havre de Grace, is president-elect.



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The Maryland Academy of General Practice

Standards for the New Specialty of Family Practice

G. OVERTON HIMMELWRIGHT, MD

Past-President, Maryland Academy of General Practice

In the May issue of this Journal the *Evolution of a New Specialty* was presented. This outlined the blueprint for the family practitioner of the future. With the development of this blue print it then becomes necessary to outline basic standards to be followed in order that this specialty will become a reality.

The Committee on Requirements for Certification (CORC), a joint *AMA-AAGP* group, is engaged in establishing standards for the new specialty of Family Practice, and early ground work on the development of examination to insure that these standards are met, have begun. After approval of the "Core Content of Family Medicine" by the *AAGP* Congress this provided the necessary ground work for the Academy to move into:

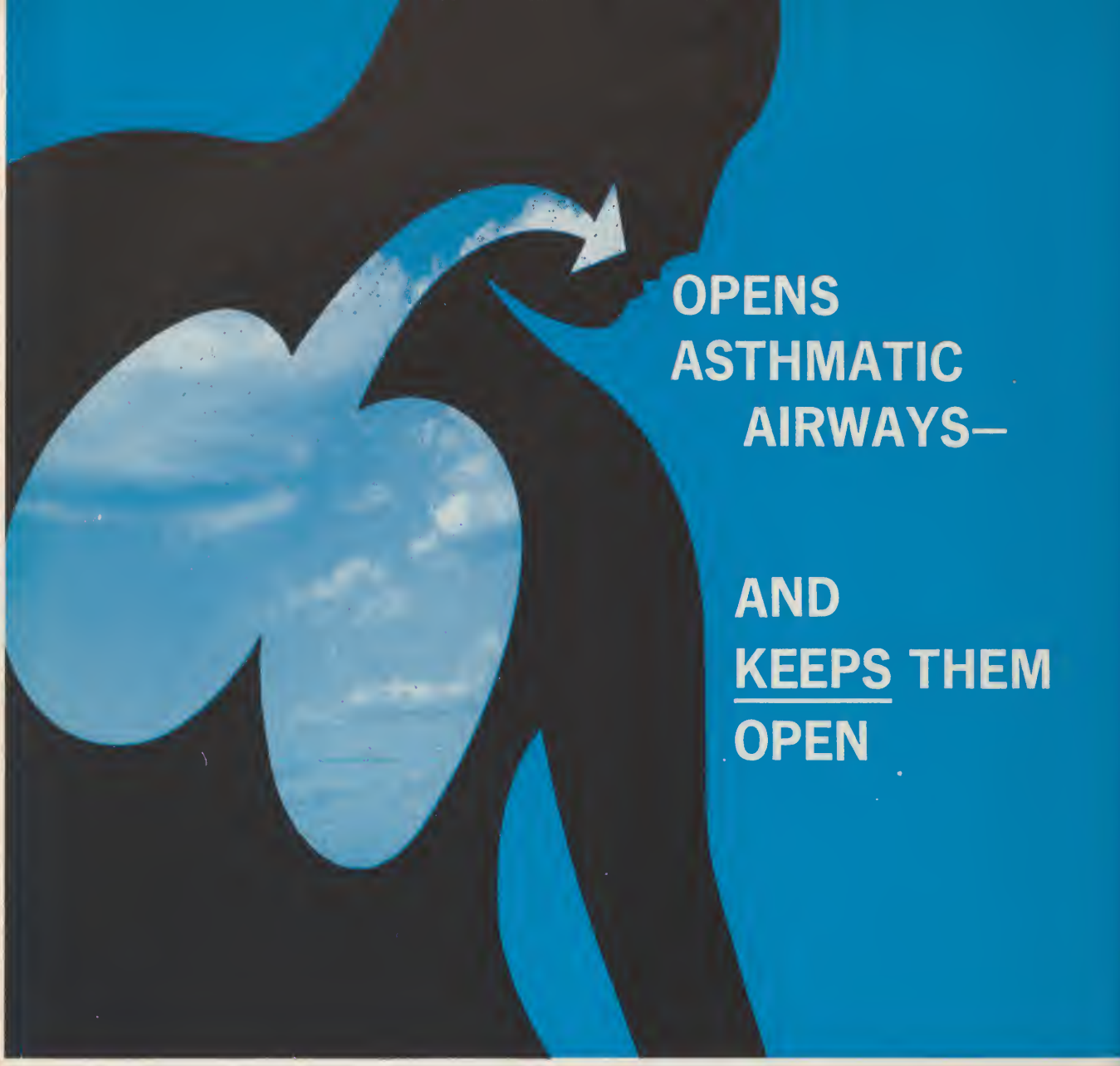
1. Translating the approved "Core Content of Family Medicine" into curriculum for graduate training programs with the results effecting even the undergraduate curricula.
2. Pursuing the formal requirements of the Advisory Board for Medical Specialties to secure approval for a primary certifying Board.
3. Developing examinations based on standards defined by the *AAGP* within the scope of the Core Content of Family Medicine.

One of the most controversial issues which the *AAGP* has met in trying to have the Family Physician approved as a Specialty with Status, which will provide for Departments of General Practice and/or Family Medicine etc. in medical education today, is that of the proposed requirements for qualification of applicants. I now quote from a paper written from our *AAGP* President, Carroll Witten, MD. "It has been and *is* the firm conviction of your *CORC* Committee that any automatic mass grand-fathering clause would be self-defeating, a detriment to general practice and to the public we serve, and indeed a serious impediment to achieving the goals we all so earnestly seek. An American Board of Family Practice must have meaning and substance from the moment it draws its first breath—not 20 or 30 years from now!"

Last October, the Congress of Delegates endorsed this concept by approving the report of the *CORC* Committee. The Congress faced the issue squarely by *defeating* two resolutions that would have written grand-fathering clauses into our considerations.

In response to the Congress and with the approval of the *AAGP* Board of Directors, this Committee proposed the following:

1. There will be no *AUTOMATIC* grandfathering.



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2. There will be two categories of eligible candidates—"Residency Eligible Candidates" and "Practice Eligible Candidates."

3. The Residency Eligible Candidates—will be comprised of those doctors of medicine who have successfully completed three years of an approved training program which meets the requirements of providing instruction outlined within the "Core Content of Family Medicine."

4. The second category is for Practice Eligible Candidates who are physicians who have been in general or family practice or members of a medical school faculty for at least six years, and who present evidence that they have during the immediate consecutive 6-year period taken 300 hours of postgraduate instruction acceptable to the American Board of Family Practice.

Members of the Academy who have successfully completed two re-election periods as active members will therefore qualify as Practice Eligible Candidates. In other words, by actual determination of the *AAGP* records some 18,000 members of our association have already fulfilled this requirement, ie, the requirement of "eligibility to be examined" as to whether or not they shall be certified.

5. Finally, it is the belief that this Practice Eligible Candidate means of eligibility should terminate on December 31, 1975.

The *AAGP* is aware that many advocates of a grand-father clause hold that position because they believe that practicing physicians who have been removed from the academic environment for a number of years would find it difficult to pass a formal test. This fear is unfounded. There are two good reasons why it has no basis in fact. First, the certifying board does not propose identical examinations for the Residency Eligible Candidates and the Practice Eligible Candidates. For, while the Residency Eligible Candidates' examination will probably have strong emphasis in the basic science aspects of medicine, the examination for Practice Eligible Candidates will have a *decided emphasis* on clinical competence testing. Second, the Academy was founded on a cornerstone of continuing education and our existing network of facilities is capable of producing concentrated refresher courses at the state and national levels that will prepare a qualified physician for the proposed examination. The opportunity to implement meaningful programs directed toward well-defined goals is tremendous. I feel that this is an area that your Academy must be cognizant about, so that we, with two schools of medicine, in the State of Maryland will be able to receive this post-graduate study. It will be necessary, also, for all members of the specialty to become re-qualified after a given period of time in the specialty in order to prove continued competence. This new specialty will be unique in its standard—because you have become a specialist in 1967 does not necessarily mean that you will remain competent in 1987, as do all the other specialties in medicine. The new Family Physician will be required to continue his education even though he will be a specialist. This is a "first" for the Family Physician, as no other specialty has such a standard. To assist family physicians to maintain skills and techniques in all the areas of the new specialty as defined by the Core Content, a coordinated system of continuing education covering all the areas in family medicine will be developed and this together with the experiences in practicing family medicine will qualify the new specialist for "re-boarding."

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REHABILITATION Notes

REHABILITATION SECTION
BALTIMORE CITY MEDICAL SOCIETY,

DOUGLAS G. CARROLL M.D.
EDITOR

The Maryland Vocational Rehabilitation Service

W. BIRD TERWILLIGER
Director, Administrative Services
Maryland State Department of Education,
Division Vocational Rehabilitation

A resource which the physician may find most helpful in obtaining a number of services designed to assist his patients in achieving their maximum economic and social usefulness, is the Maryland Division of Vocational Rehabilitation. This service, a function of the State Department of Education, is designed to help preserve, develop, or restore the ability of a disabled person to work, and is provided jointly by the State of Maryland and the Federal Government. Vocational Rehabilitation is broadly defined as the restoration of the handicapped to the maximum physical, mental, social, vocational, and economic usefulness of which they are capable. The program is not only humanitarian, in that it prepares disabled persons to hold positions of dignity and respect in society; but it is also economically sound, in that it prevents dependency, increases the circulation of money and the consumption of goods, and returns to the State and Federal Governments in tax money larger amounts than the cost of the program.

SERVICES AVAILABLE

The Division of Vocational Rehabilitation can provide a variety of services designed to enable persons permanently handicapped by accident, disease, or congenital conditions to recognize and make use of their remaining capabilities.

Evaluation

A complete evaluation, medical, psychological, vocational, and social, is secured on each applicant for service without any cost to him. Medical information is obtained from the family physician and other physicians who are familiar with the client's condition, and if necessary, further diagnostic studies, including in-hospital studies where indicated, may be provided by the Division in order to determine the existence and extent of impairment, the probable future course of the disabling condition, and what if any restorative measures can be taken to remove or reduce the disability.

Psychological evaluation is obtained where indicated to determine the client's level of mental functioning and to discover aptitudes, abilities, and skills which may be utilized in his vocational adjustment.

Vocational and social evaluation are accomplished through interviews with the client, his family, his school authorities where appropriate, previous employers, and other persons who have knowledge of his character and vocational potential.

Guidance and Counseling

Trained vocational rehabilitation counselors interpret to the client the results of the evaluation, and explore with him the possible courses of action which might lead to a satisfactory vocational adjustment. This service may be minimal, as in the case of a client with a good work history and

usable skills who needs merely a single service to enable him to return to work, or it may require many hours of counseling regarding the physical and mental capacities of the client, job requirements in a variety of occupations, the client's attitude toward work, and the various steps that will be required in order for the client to prepare for and enter employment. Guidance and counseling are provided without any cost to the client.

Physical Restoration

If the physical or mental condition of the disabled person can be substantially improved by medical, surgical, psychiatric or other treatment, or by the provision of a prosthetic device, to such an extent that his vocational potential is thereby increased, the Division will secure such treatment or prosthesis through cooperation with physicians, hospitals, and other medical and paramedical resources. The provision of physical restoration services, with the exception of prosthesis, through the use of public funds, is contingent upon the economic circumstances of the client.

All of the medical aspects of the program, with respect to both evaluation and physical restoration services, are under the supervision of a State Medical Advisor and District Medical Advisors in each district. Division policy with regard to medical matters is established by a Medical Advisory Committee consisting mainly of physicians representing each of the appropriate specialty fields, but with representation also from such paramedical fields as physical therapy, occupational therapy, nursing, and hospital administration.

Such treatment or care may be provided only for conditions which are stable, or slowly progressive, and not for acute conditions except as such conditions may arise *during* the rehabilitation program of the client and endanger the successful completion of the rehabilitation process.

Vocational Training

When, as a result of the evaluation process, there is indicated for the client a vocational objective requiring knowledges or skills which he does not possess, but for which he demonstrates aptitude and potential ability, the Division will provide training in the necessary academic or manual skills. The training may be obtained in public or private schools, by tutoring or correspondence, or in an on-the-job situation. Preference is given to public educational facilities within Maryland, but if the desired training cannot be obtained in these, any approved faculty may be used. Within Maryland, only those training facilities are used which are approved by the State Department of Education or other appropriate accrediting body. Only such out-of-State facilities are used as are approved for use by the Vocational Rehabilitation agency in the other State.

There is almost no job which some handicapped person cannot perform when properly trained, and the Division will provide whatever training, vocational, technical, or professional, may be necessary to enable the disabled person to attain the greatest potential of which he is capable. Training may provide a simple or complex skill for a person who has never been employed, or it may provide a new skill to an experienced worker who because of his disability cannot continue in or resume his former occupation. For example, a highly skilled and highly paid structural steel worker who becomes a paraplegic as a result of an accident may be trained as a draftsman, a watch repairman, or perhaps an accountant, according to his capabilities.

Any training provided by the Division is without cost to the disabled person.

Maintenance

The Division is not a public assistance agency, and in general cannot assume responsibility for the ordinary living needs of the disabled person or his family. However, if the client must live away from home during the process of physical restoration or training, or if he has no home and no other means of subsistence are available, the Division can provide maintenance for the duration of the rehabilitation process.

Placement and Follow-Up

The responsibility of the Division does not cease until the client has been placed in employment, and the employment has been determined to be satisfactory to both the client and the employer. Many clients return to their former occupations or otherwise obtain their own jobs. Others are referred to the Maryland State Employment Service for placement. It is ultimately the rehabilitation counselor's responsibility, however, to assist his client in obtaining employment, and in a large number of cases the counselor makes employer contacts for and with the client until satisfactory employment has been obtained. This

is necessary particularly where the disability is one which encounters considerable employer resistance, such as epilepsy, mental illness, paraplegia, or quadraplegia.

The counselor must also follow the client's progress on the job for a period of time long enough to demonstrate that the employment is suitable with respect to the disabling condition, ie. that the client can do the work and that the work or the workng conditions are not likely to aggravate the disability; and that the employer is satisfied.

ELIGIBILITY

There are three basic requirements for eligibility for vocational rehabilitation services:

1. There must exist a physical or mental disability which results in an impairment of function;
2. As a result of this functional impairment there must be a substantial handicap to employment; and
3. There must be reasonable expectation that the provision of vocational rehabilitation services will enable the person so handicapped to enter gainful employment.

(*Gainful employment* is interpreted to mean work for which payment in cash or in kind is received. For example, a family worker whose work releases the other members of the family for outside employment is said to be gainfully employed.)

There are other obvious eligibility requirements such as residence within the State, an appropriate age for employability, and the ability, or potential ability to manage ones own affairs without constant supervision; but no distinction can be made on the basis of sex, race, color, creed, or national origin of the disabled person, or the type of disability.

The basic requirements listed above indicate clearly that not every impairment constitutes a disability, nor does the existence of a disability necessarily result in a substantial handicap to employment. A bookkeeper who loses both legs in an accident may continue his former employment; not so a steeplejack. The bookkeeper, however, may need assistance in the fitting and obtaining of prostheses in order to return to work, and so may not be eligible. This the rehabilitation counselor must decide.

ORGANIZATION FOR SERVICE

The Maryland Division of Vocational Rehabilitation provides services through six district offices and thirteen local offices throughout the State. Each district is staffed by a supervisor, with perhaps an assistant, rehabilitation counselors, a medical advisor, and supporting clerical personnel. Rehabilitation units are operated by the Division in all of the State mental hospitals (the Springfield State Hospital Unit will not be in operation until after July 1, 1967). There is also a unit in the Correctional Institution for Males, in Washington County, which provides services to those public offenders who have physical or mental disabilities. It is anticipated that service will be extended to other correctional institutions as staff and funds become available.

Special units for providing services to school age children are also operated in cooperation with the public school systems of Baltimore City and several counties. This service also will be extended throughout the State as rapidly as possible.

EFFECTIVENESS

An indication of the economic value of this program is given in the results from client follow-up studies which the Division conducts from time to time. In fiscal year 1964, the most recent year on which a follow-up study has been made, the total cost of the Vocational Rehabilitation Program in Maryland was $1,633,761. Of this amount, State funds accounted for $690,345 and Federal funds for $943,415. During the year, 6,670 clients were served by the Division. Of this number 1,974 were rehabilitated into employment. Many of the others who were served were rehabilitated into employment in subsequent years. As a result of the follow-up survey, complete information was obtained on 794 of the clients who were rehabilitated in 1964. The total earnings of these rehabilitants from the time of closure until Dec. 31, 1966, amounted to $5,464,110. This is approximately 16 times the cost of their rehabilitation, which was $343,008, and approximately 4 times the total cost of the whole rehabilitation program in 1964.

The rehabilitated clients had an average of one dependent each and earned an average of $2,468 per year. If they worked at this rate for only one year, they paid taxes amounting to $254 each or a

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total of $501,396, 52% of the total cost of their rehabilitation.

1,183 persons were removed from a state of dependency, either upon families or upon public assistance, thus releasing a considerable amount of money for other needs. Many others, while not in a state of dependency, were rapidly consuming their savings and other resources and undoubtedly would have become dependent at a future date.

HOW CLIENTS MAY BE REFERRED FOR SERVICE

Referral of disabled persons for service may be made to any district or local office, each of which is listed in the appropriate local telephone directory, or to the State Office, Division of Vocational Rehabilitation, 2100 Guilford Avenue, Baltimore—21218.

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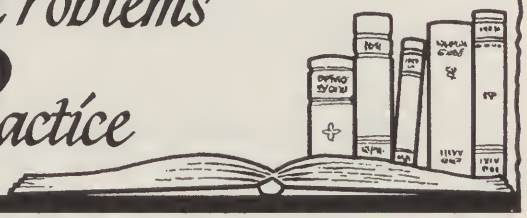
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All About Aides-Part IV

"Why Doctors Lose Aides"

WILBURN L. McCLURE, JR.

It is not easy to get good help these days. That is a recognized fact. Why then, do many doctors experience a high attrition rate in their offices? and with a representative of the State Department

A quick check with several personnel agencies and with a representative of the State Department of Employment Security revealed two very interesting facts: (1) They receive most of their calls from repeaters—those looking for another aide; and, (2) The demand is far greater than the supply.

The assistance of several aides was solicited to glean facts as to why they left former employers and as to why they might leave their present one. Here are a few of the most repeated statements.

Increasing Responsibilities: "Most doctors don't fully appreciate the ever-increasing problems handled by their aides."

"Some doctors actually believe that their aides say 'Hello' to the patients and lock the doors at night. That's all."

"My doctor's volume went from about $30,000 at the time I was hired to over $80,000. He hired an associate physician to help him. The volume is now over $100,000. They don't think I need a full-time assistant. To compensate for the tremendous increase in work, they gave me a $5 raise. I quit. In the past two months they have had five aides. They simply don't understand that it's not a one-girl office."

Credit where credit is due: "The office was greatly disorganized when I arrived on the scene. Two months later, after many extra hours without pay, the office was in top notch condition. One day the doctor remarked that it seemed as if the office were running more smoothly lately for some reason or another. I could have cried."

"Patients' continuous expressions of respect and gratitude provides doctors with their greatest satisfaction. Consider the effect this could have on an aide who is also trying to do the best job possible."

Salary arrangements: "Medical secretaries and aides are known for their dedication to their employers. Not many doctors take this into consideration when salary increases are due or long overdue."

"In my twenty-five years of working with doctors I've yet to hear of one who had a salary

---

Mr. McClure is director of the Baltimore office of Professional Business Management, Inc. This monthly column is prepared as a complimentary service to the *Maryland State Medical Journal.*

scale to secure the future and stimulate the morale of his aides."

Many other interesting ideas were brought to light through the interviews. It seems as if many offices lack adequate equipment, proper working space, and respect for hours the aides are paid to work.

Frustration seems to be another predominate issue with aides. It seems as if there is a genuine lack of communication between doctor and aide. This is particularly true when it comes to letting the aide know where the doctor is at a given hour; about the patients told to "come on in" without saying anything to the aide; extending or changing office hours without notice; and, seldom asking the aides when they would like their vacation.

The compiling of material for this article was an eye-opening experience. Chances are, Doctor, you'll find many startling comments from your aides if you give them a few minutes of undivided attention to ventilate their ideas and complaints.

In order to give them a fair chance, provide the following agenda for review prior to the session. Ask them to be ready with their comments on the following subjects:

1. Working space
2. Equipment
3. Duties and Responsibilities
4. Working Hours
5. Salary
6. Communications

A session, like the one mentioned above, should be conducted at least once a year. You'll find them to be informative and great morale builders.

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Learn To Do Your Part In The Prevention Of Disease

New Bureau of Special Home Services

On July 1 Operation *REASON,* a demonstration project to aid Baltimore's elderly and the infirm, particularly in inner city areas, becomes an administrative unit of the Baltimore City Health Department to be known as the *Bureau of Special Home Services.* Mr. Bailey Conaway, *MSW, ACSW,* director of the program, was appointed by the Health and Welfare Council of the Baltimore Area at the time the project was established in July 1965 with a grant of $112,650 from the U. S. Office of Economic Opportunity.

Operation *REASON,* so named as an acronym for a program of "Responding to the Elderlies' Abilities and Sickness Otherwise Neglected," has a current staff of 41 persons. Its main focus as the new Bureau of Special Home Services in the City Health Department will be to assist the aged poor to obtain the medical services they need for which they are eligible.

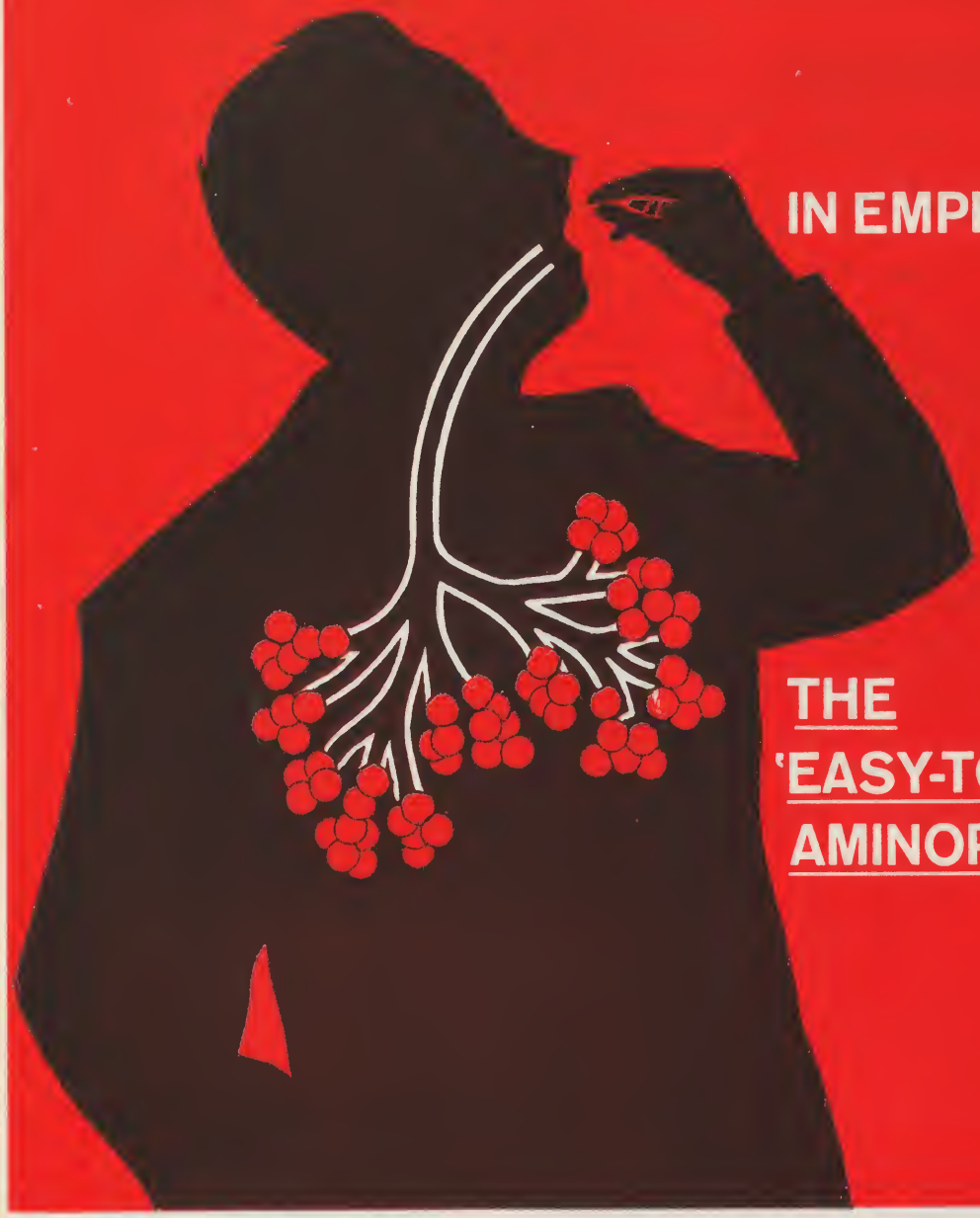
During the past two years Operation *REASON* has aided over 800 aged persons with physical, emotional and social problems. With the assistance of many cooperating agencies this work has enabled many of our older residents to overcome their disabilities or modify them to the extent that they can face their later years with a greater feeling of security and less misery and despair. While the project will be administered by the City Health Department, the funds for its operation will be provided chiefly by the Federal Government through the Community Action Agency.

Mr. Conaway, whose title will be Director of the Bureau of Special Home Services, has had a wide experience in medical-social work. He has been a caseworker in the Children's and Protective Services Division of the City Department of Public Welfare, a school social worker with the Baltimore Public Schools, Supervisor of Foster Care Services at Springfield State Hospital, psychiatric social worker for the Mental Health Clinics of the Maryland State Department of Health, and a consultant in psychiatric social work for the National Institute of Mental Health.

The new bureau staff comprises the following: assistant director, Miss Adele Wilzack, MS; clinical director, Bernard Harris, Jr., MD; social workers, Mrs. Harriet W. Jones, *MSW, ACSW,* and Mrs. Christine B. Hall, *MSW, ACSW*; health aide supervisors are Mrs. Myrtle Einhorn and Mrs. Celia Crawford, both of whom began in the program as Health Aides and who through superior work performance have been promoted to supervisory positions. There are also 30 Health Aides predominantly residents of the inner city and over 60 years of age who provide direct services to clients.

The new Bureau of Special Home Services will be on the 14th floor of the American Building, Baltimore and South Streets, where the central City Health Department administrative offices are located

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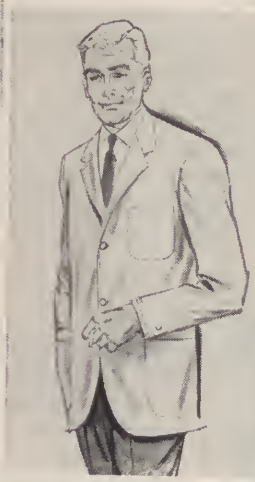


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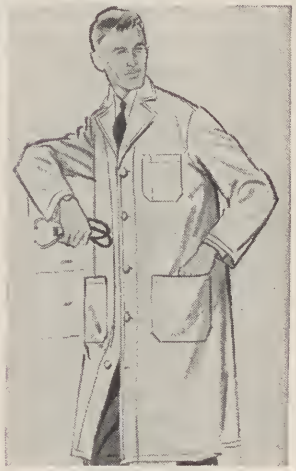
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September 22—1:00 PM

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Lawrence S. Cohen, MD, National Heart Institute, National Institute of Health.

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September 29—12:30 PM

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Paul P. Carbone, MD, National Cancer Institute, National Institute of Health.

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October 6—12:30 PM

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October 13—12:30 PM

DIAGNOSTIC PROBLEMS

Panel Discussion
Moderator: Thaddeus E. Prout, MD, Chief of Medicine, Greater Baltimore Medical Center.

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October 20—12:30 PM

MANAGEMENT OF MULTIPLE SEVERE INJURIES

Moderator: John C. Stauffer, MD, Hagerstown.
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October 27—1:00 PM

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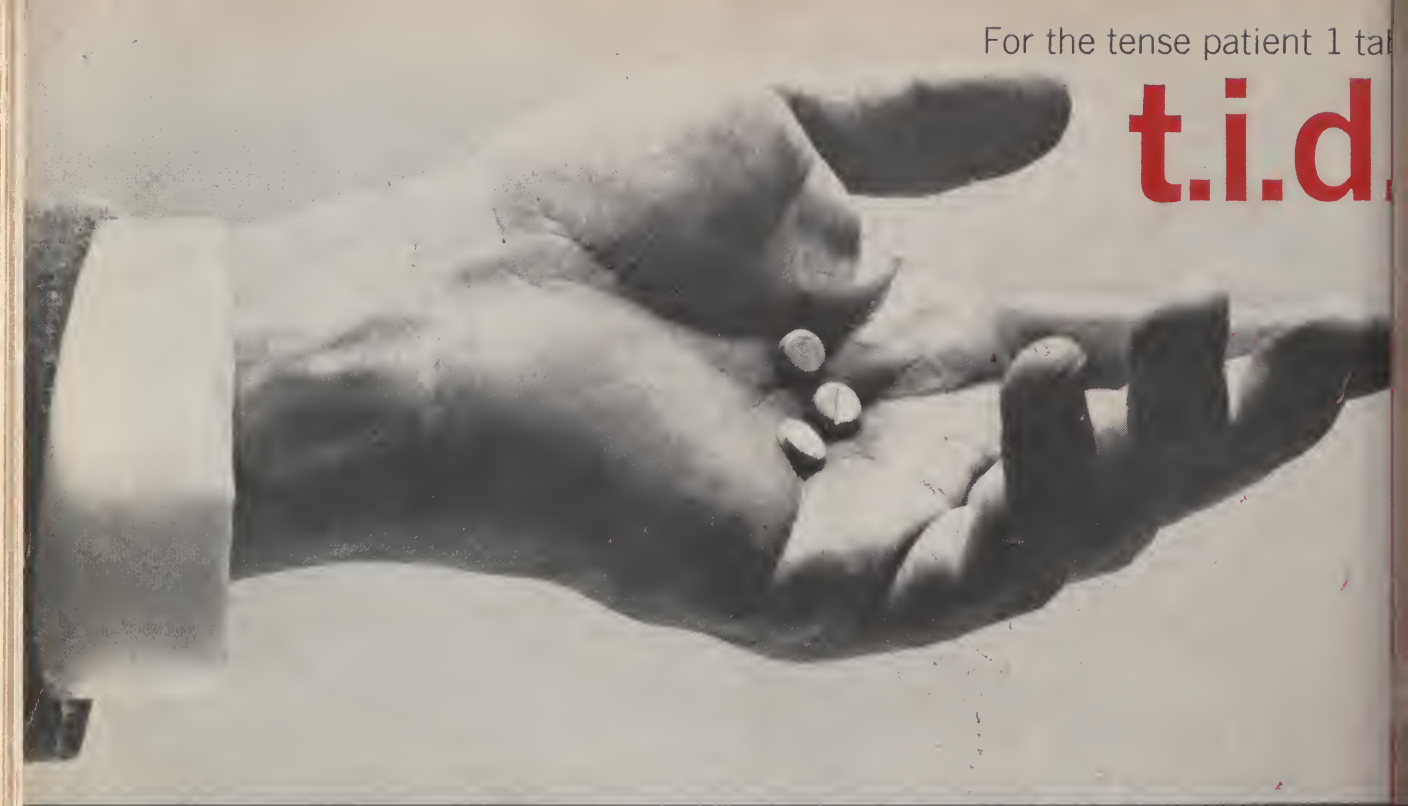
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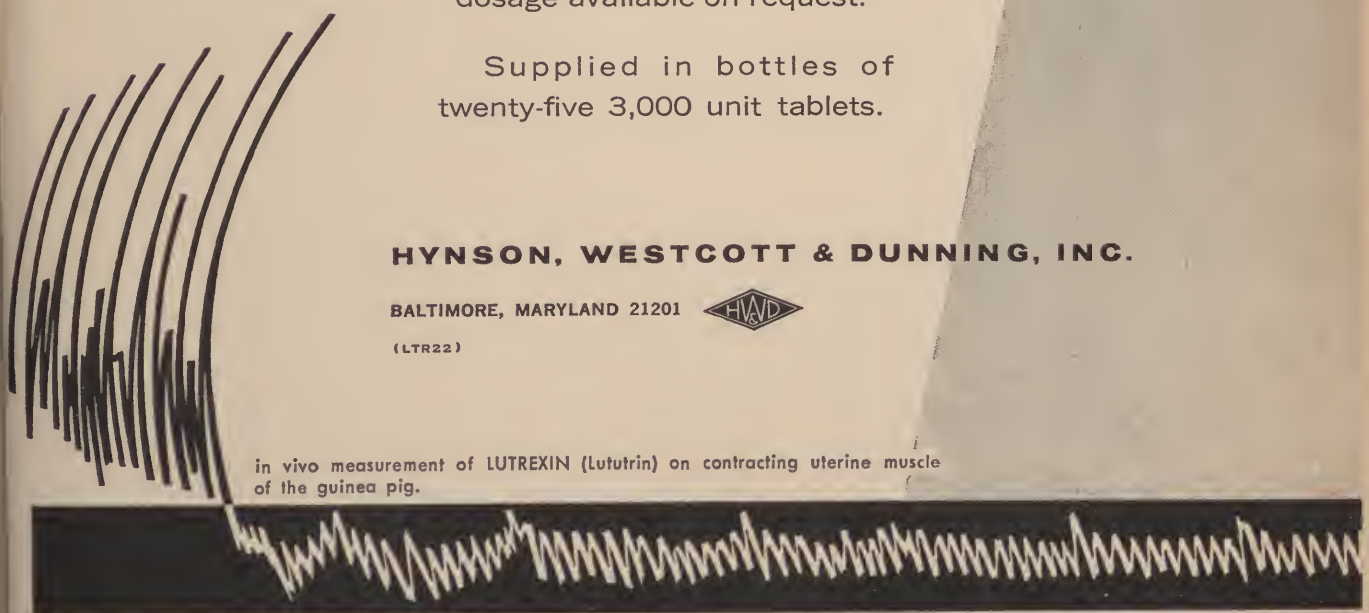
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THERAPEUTIC ABORTION— A VERY TIMELY TOPIC

Whether or not to liberalize therapeutic abortion laws—one of the most controversial issues in recent years—is now being debated in religious and legal circles as well as in newspaper editorials and state legislatures throughout the country.

Bills designed to revamp existing laws have been introduced in twenty-one state legislatures so far this year and recently Colorado, North Carolina and California have enacted legislation which will permit abortions for reasons other than those generally permitted—to perserve the mother's safety, health or life.

According to the *AMA* News most states seeking to broaden their abortion laws are patterning their bills after the American Law Institute's model penal code which would permit abortion: 1 to prevent grave impairment to the physical or mental health of the mother; 2 when there is substantial risk the child will be born with grave physical or mental defect or 3 when the pregnancy results from rape or incest, and there is authoritative certification.

The *ALI* code further specifies that these pregnancies should be terminated only in certified hospitals by a licensed physician after two other physicians agree that the procedure is justified.

Certainly the matter of therapeutic abortion, as well as being a moral and religious problem, is also a medical problem. Many state and county medical societies recognizing the fact that therapeutic abortion is a medical problem have already taken active roles in reviewing and advising on existing and proposed legislation.

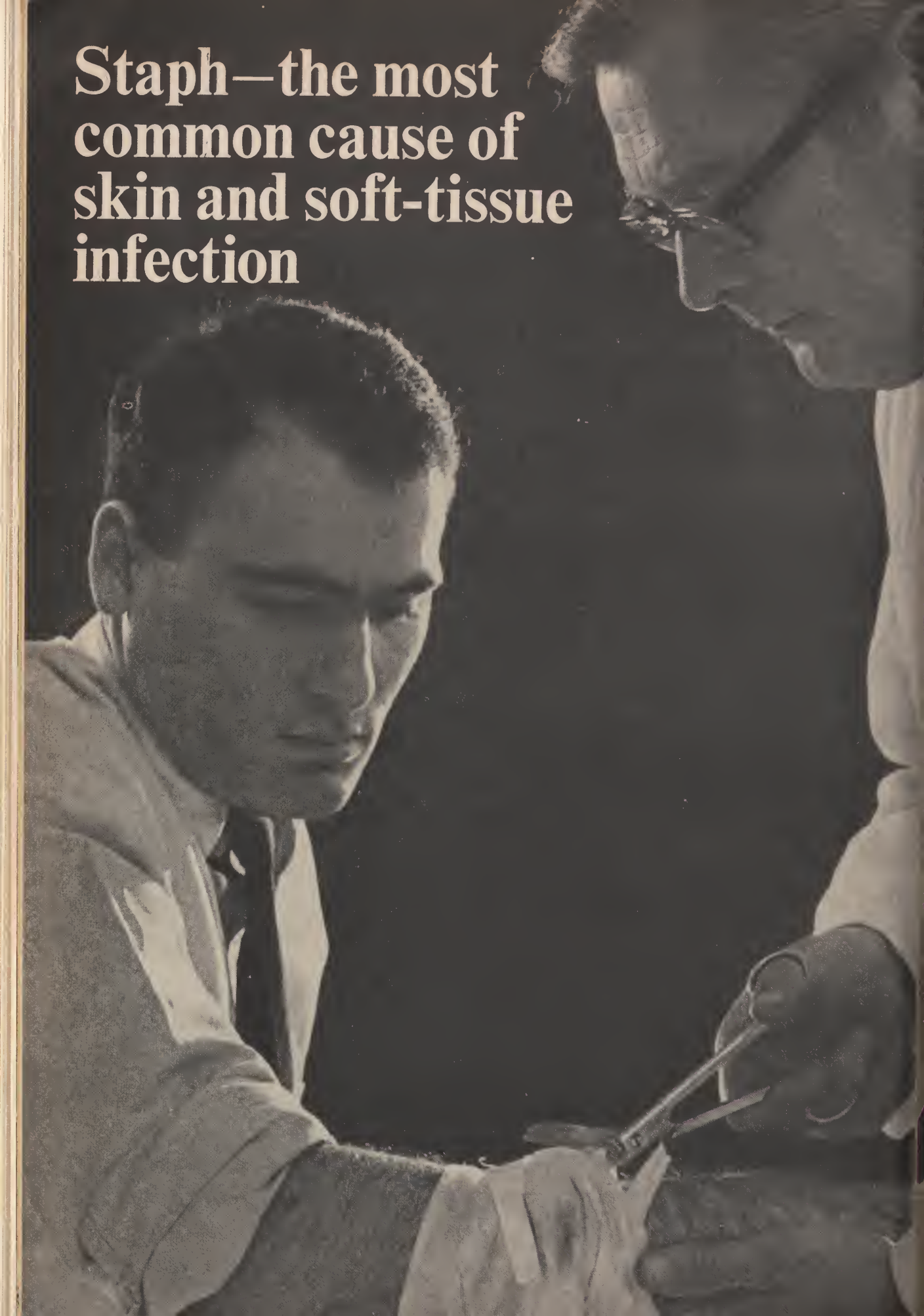
Reprint from the American College of Obstetricians and Gynecologists Newsletter, July, 1967, Page 1, 2, 79 West Monroe Street, Chicago, Ill.

The California Medical Association endorsed the state's bill at the time that it was proposed, and in February the House of Delegates of the medical society of New York State reaffirmed their 1966 guidelines for therapeutic abortions. In praise of the action of the New York group, Henry F. Marasse MD, wrote in the Winchester New York Medical Bulletin: "Time and again we stand accused of forfeiting our role of leadership in maintaining essential standards of professional practice. It is no exaggeration to say that most of the major changes in the field have been forced upon us by lay pressures. The regulation of the medical indications for abortion is no exception."

Last December the King County Washington Medical Society appointed an ad-hoc committee to meet with the bar association to draft appropriate legislation. Robert F. Willkens MD, wrote in comment at the time "we are often accused of failing to take the initiative in health care. Here is an area in which we can and should provide guidance and leadership—abortion has rested in the silent twilight of American medicine long enough. We endorse the appointment of the trustees of the committee which we hope will act with speed and effectiveness."

Probably the most active role taken in the matter of therapeutic abortion was taken last March by the Illinois State Medical Society. At that time it became apparent to members of the society that a great deal of confusion existed in Illinois regarding demands for a change in the law versus equally strong demands for a status quo situation. This led to a great deal of indecisiveness on the part of the state legislature regarding a new abortion bill which was then about to be intro-

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Bactericidal effectiveness. Hardly a staph organism can resist the bactericidal action of Prostaphlin (sodium oxacillin), as shown by a 34-month *in vitro* study. Of all staph isolates tested, 99.5% were sensitive to oxacillin.[1]

Clinically proven. There is a high correlation between these *in vitro* findings and clinical results. Of 610 patients treated with Prostaphlin (sodium oxacillin), 89.8% were reported cured or improved, including those with staph infections resistant to penicillin G.[2] And since resistance does not appear to develop *in vivo,* therapy with oxacillin can be extended when necessary.

Outstanding safety record. Besides being staph-specific and rapidly absorbed—Prostaphlin (sodium oxacillin) has established an outstanding record of safety during five years of widespread clinical use. Continuous high blood levels of oxacillin have not produced toxic effects on kidney function, assuring a significant margin of safety. However, as with all penicillins, the possibility of allergic response should be considered.

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References: 1. Abstracted from *Antibiotic Sensitivity of Staphylococci Studied from November 1962 through August 1965,* reported by Griffith, L.J., Staphylococcus Reference Laboratory, V.A. Hospital, Batavia, N.Y. 2. Data on file, Bristol Laboratories.

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duced in the legislature. At this time the Illinois State Medical Society recognized a need and an opportunity to offer service and leadership to the public. Accordingly it scheduled a public symposium of therapeutic abortion to air both the "liberal" and "conservative" points of view.

Robert R. Hartman, MD, FACOG, who was chairman of the *ISMS* committee on maternal welfare, was appointed chairman of the symposium planning committee. At the time of his appointment, Doctor Hartman said "to the best of our knowledge this is the first time a state medical society has sponsored a public forum at which a panel composed entirely of physicians discussed a law which circumscribes their conduct."

The planning committee was comprised of representatives of the state legislature, public affairs and maternal welfare committees and the legal profession. The first decision that the committee made was to limit the discussion strictly to the medical implications of therapeutic abortion. It was the feeling of the committee that any discussion of the religious and moral overtones was more properly within the realm of the clergy and sociologists.

A basic consideration involved program format. So as to achieve the balance of liberal and conservative viewpoints previously mentioned the committee selected eight panelists—four "pro" and four "con" from the four major specialties of obstetrics, pediatrics, psychiatry, and public health with the hope that this would provide a good cross-section of balanced viewpoints.

Once the program was set, and as soon as the panel members were selected, an all out program was inaugurated to get maximum publicity. The symposium was to be held in the Sherman House ballroom in Chicago and was open to the public. All the publicity efforts were highly successful and all of the Chicago news media cooperated completely giving priority publicity to all aspects of the symposium.

In view of the fact that an overflow audience was expected, WFLD-TV video-taped the symposium and telecast it the same night during a prime time segment as a public affairs program. To build an audience for the telecast the station published ads in both the Sun Times and the Daily News and also included a questionnaire ballot to be filled out by the audience to measure the feed-back response. Even though the questions were asked only once at the end of the telecast the station received 1,119 responses in the mail which indicated that 86.7% favored abortion if the mother's life was in danger; 77.7% favored it if the pregnancy was caused by rape; 73.1% were in favor if the mother's mental health was threatened, and 72.1% favored it if the child was likely to be deformed. Ten percent thought all abortions should be forbidden.

Editors throughout the area felt that the symposium was most timely and of high news interest. The staffs of all the Chicago daily newspapers, the Associated Press, three radio stations, five television stations and several medical publications were present for the meeting.

All indications and all responses would indicate that this symposium was extremely successful. The symposium brought the question of therapeutic abortion out of the shadows of silence, reviewed and analyzed it in a spotlight of educational publicity, and most important, put the medical profession in the forefront of leadership in this highly controversial issue.

The College has named a committee of ten members to study this matter and to make proposals in this regard at the 1968 Annual Meeting. The House of Delegates of the *AMA* adopted a resolution at their recent meeting in Atlantic City which is generally along the lines of the previously mentioned *ALI* model code.

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Committee on Human Reproduction

AMA POLICY ON THERAPEUTIC ABORTION

At its meeting in Atlantic City in June 1967 the *AMA* House of Delegates considered a detailed report and policy recommendation on therapeutic abortion which had been prepared by the Committee on Human Reproduction and transmitted to the House with the approval and recommendation of the Board of Trustees. The report recommended that the *AMA* adopt a policy on therapeutic abortion which, in essence, is a modification of the Model Penal Code of the American Law Institute. The proposed new policy did not address itself to state abortion laws.

This report evoked widespread interest and discussion at the Atlantic City meeting. All points of view were expressed with the preponderance of testimony favoring adoption of the recommendations. After lengthy debate and some minor modifications, the following statement was adopted as the policy of the American Medical Association:

> The American Medical Association is cognizant of the fact that there is no consensus among physicians regarding the medical indications for therapeutic abortion. However, the majority of physicians believe that, in the light of recent advances in scientific medical knowledge, there may be substantial medical evidence brought forth in the evaluation of an occasional obstetric patient which would warrant the institution of therapeutic abotion either to safeguard the health or life of the patient, or to prevent the birth of a severely crippled, deformed or abnormal infant.
>
> Under these special circumstances, it is consistent with the policy of the American Medical Association for a licensed physician, in a hospital accredited by the Joint Commission on Accreditation of Hospitals, and in consultation with two other physicians chosen because of their recognized professional competence who have examined the patient and have concurred in writing, to be permitted to prescribe and administer treatment for his patient commensurate with sound medical judgment and currently established scientific knowledge. Prior to the institution of a therapeutic abortion, the patient and her family should be fully advised of the medical implications and the possible untoward emotional and physical sequelae of the procedure.
>
> In view of the above, and recognizing that there are many physicians who on moral or religious grounds oppose therapeutic abortion under any circumstances, the American Medical Association is opposed to induced abortion except when:
>
> (1) There is documented medical evidence that continuance of the pregnancy may threaten the health or life of the mother, or
> (2) There is documented medical evidence that the infant may be born with incapacitating physical deformity or mental deficiency, or
> (3) There is documented medical evidence that continuance of a pregnancy, resulting from legally established statutory or forcible rape or incest may constitute a threat to the mental or physical health of the patient;
> (4) Two other physicians chosen because of their recognized professional competence have examined the patient and have concurred in writing; and
> (5) The procedure is performed in a hospital accredited by the Joint Commission on Accreditationof Hospitals.
>
> It is to be considered consistent with the principles of ethics of the American Medical Association for physicians to provide medical information to State Legislatures in their consideration of revision and/or the development of new legislation regarding therapeutic abortion.
>
> In adopting this statement, the House of Dele-

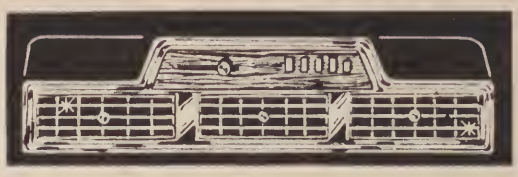
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gates stressed that the rights of physicians to express contrary views and to practice their beliefs must be respected but that the new policy in no way suggests that physician or patients act contrary to their personal consciences. The House characterized the statement as one which is "in keeping with modern scientific knowledge, contains necessary safeguards, and permits the physician to exercise his personal conscience and medical judgment in the best interest of his patient." These should be the overriding objectives in any medical decision.

Finally, the House of Delegates noted the unmistakable evidence of restiveness in all segments of the population regarding our current therapeutic abortion practices and stated that "it is clear that change and reform in this area is inevitable." The House stated its belief that the new policy "is a reasonable and conservative approach" which will provide the American Medical Association with a position of leadership in this important contemporary problem.

Sports Authorities Warn Against "Spearing"

A group of coaches, physicians, and sports officials today joined the American Medical Association in calling for an end to football "spearing."

Spearing is the tactic in which a blocker or tackler uses his head as a battering ram. It's dangerous, both for himself and for the person he hits.

The football authorities called for coaches to emphasize correct, head-up blocking and tackling, and for strict enforcement by officials of the rules against spearing.

When polled by the American Medical Association's Committee on the Medical Aspects of Sports, the group was unanimous in warning against spearing. The *AMA* committee asked for their comments when recent studies showed that head and neck injuries continue to constitute a very high percentage of serious injuries in football.

Said Notre Dame football coach Ara Parseghian: "I can't begin to tell of the number of clinics where I have lectured on the (spearing) problem. We don't teach this at Notre Dame; and over the years, I have done everything within my power to influence others to coach against it."

A tackler can inflict a tremendous amount of punishment by driving his helmet into an opposing ball carrier. Moreover, he endangers himself, because his head and neck take the force of the blow. Serious injury and even death have resulted from damage to brain areas or the spinal cord.

In the correct, head-up tackle, the player uses his shoulders, arms, and chest to stop the ball carrier. In a "spear" or "butt tackle," he drives into his opponent with his head. By spearing, the tackler may prevent the ball carrier from advancing a few extra inches—if he tackles him. With his head down, however, he not only risks serious injury, but is more likely to miss the tackle because he has a harder time seeing where he's going.

"Many neurosurgeons are appalled by coaches permitting or even deliberately teaching the devastating techniques of 'spearing,' 'stick-blocking,' and 'head-butting'," said Richard C. Schneider, MD, an Ann Arbor, Mich., neurosurgeon and member of the *AMA* Committee on the Medical Aspects of Sports.

He pointed out that death may be only 30 to 60 seconds away if the blood vessels draining the brain are damaged by a heavy blow, or if hemorrhaging begins within the brain.

In the neck, the spinal cord is approximately the size of a man's ring finger. It lies within the bony spinal canal, an easy victim of bruising or cutting if neck vertebrae or cervical discs are forced out of place, Dr. Schneider said.

Such an injury may result in death or permanent paralysis of arms and legs and loss of bladder and bowel control. Thirty such cases were reported during the football seasons of 1959 through 1964, he said.

Studies of fatalities indicate that football has a good safety record, considering that virtually a million players are involved each fall. It could be even better, however, if head and neck injuries could be reduced. In 1966, head and neck injuries were responsible for 23 of the 24 fatalities directly attributed to injuries in college and high school football.

"Strict enforcement by officials of the rule against 'spearing' is important," said Donald B. Slocum, MD, chairman of the *AMA* committee and orthopedic consultant to the University of Oregon football team. "While every infraction may not be discernible, those that are should be rigorously penalized—particularly those that occur on second impact when a runner already has been tackled," Dr. Slocum said.

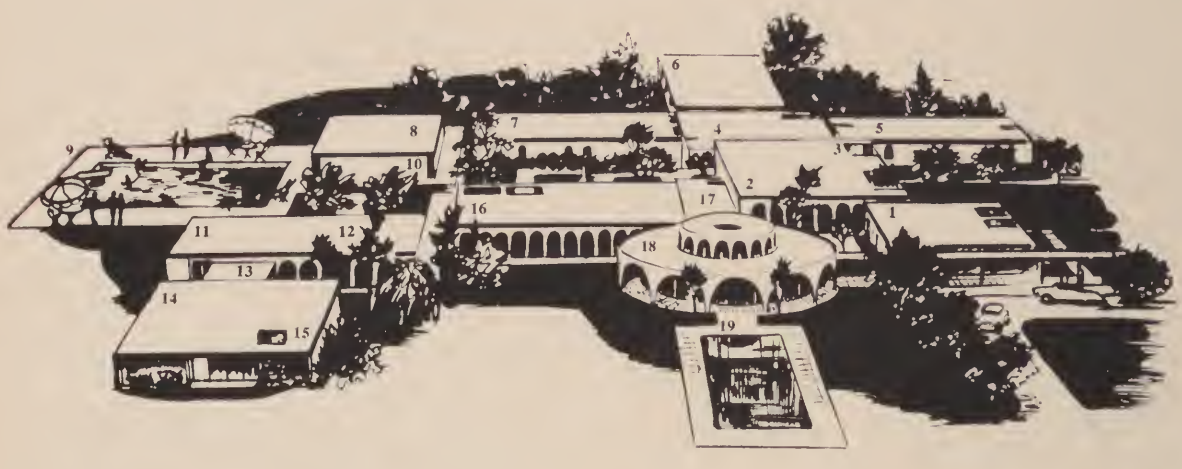
Although rules committees on all levels have voted for stricter enforcement of the "spearing rule," many players continue to spear in blocking and tackling, either inadvertently or as a definite

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tactic, said William E. Newell, executive secretary of the National Athletic Trainers Association and head athletic trainer at Purdue University.

Players should be selected and trained more carefully, he said, particularly boys at two physical extremes—those with long, thin necks and those with short, stubby necks.

"Protective equipment is no guarantee against serious or even fatal football injuries," Newell said. "With proper attention, however, injuries from the so-called spear or butt block can be eliminated or greatly reduced in football at all levels."

Said Clifford B. Fagan, executive secretary of the National Federation of State High School Athletic Associations: "There is absolutely no place in interscholastic football for 'spearing.' Responsible athletic administrators and football leaders everywhere deplore the fact that a small number of coaches teach it. The high rate of serious injury which results from 'spearing' makes it self-evident that the teaching of its must not be tolerated. There are a great variety of safer blocking methods which are as effective as spearing and infinitely safer."

Elimination of spearing "would certainly cut down the number of fatalities in football," said L. W. Combs, MD, director of the student health center, Purdue University, and a leader in the Athletic Medicine Section of the American College Health Association.

"It has been disappointing for me as a team physician at a university to realize that some high school coaches are teaching 'spearing' as being a sound football practice," Dr. Combs said. "At the college level, we are very much aware that this technique makes the player much more vulnerable to injuries of the head and neck. The headgear has been highly developed by equipment manufacturers with the advice of physicians, trainers, and others as a protective gear. It is entirely unfitting, however, that some coaches persist in teaching its use as an offensive and defensive weapon."

"The primary problem is the present coaching techniques of 'butt' tackling or blocking. It is impossible for the rules committees to legislate 'coaching techniques'," said O. B. Murphy, MD, of Lexington, Ky., University of Kentucky team physician and representative of the *AMA* committee to the *NCAA* Rules Committee.

"In any case," he said, "the fact remains that since the advent of the hard helmet and face piece, coaches have felt that the head and face are adequately protected. This, however, affords no protection at all for the neck which is subjected to injury through this repeated 'butting' technique."

Said Murray Warmath, football coach at the University of Minnesota: "spearing will never disappear from the game until we quit coaching it and until we absolutely disallow its use on the part of our men."

"It isn't the first man who makes the tackle," Warmath said. "It's that second tackler. He puts his head down, closes his eyes, and piles into the man who's down with one intent, and that's to maim and cripple."

Since 1960, most of the football deaths resulting directly from football participation have been caused by head and neck injuries, said Carl Blythe, PhD, of Chapel Hill, N.C., chairman of the *NCAA* committee on football safety and president of the American College of Sports Medicine.

"The practice of spearing is condemned by all responsible persons truly interested in the game of football and the welfare of its participants," he said.

The *AMA* committee has waged a continuing campaign for prevention of injuries to the head and neck since it sponsored a "National Conference on Head Protection for Athletes" in Chicago in 1962. The Conference recommended that spearing be outlawed, but the practice persisted.

"Perhaps the only answer is the creation of public awareness of this problem to the point that a player who uses spearing will be branded as guilty of unsportsmanlike conduct," said a spokesman for the committee. "Anyone who would deliberately set out to injure his opponent, by spearing, while at the same time endangering his own life must be lacking in moral values and intelligence," he said.

The *AMA* Committee on the Medical Aspects of Sports called on all team physicians to discourage spearing, urged coaches to teach against the tactic, and warned players of the dangers of the practice. Concerted action to rid the game of spearing can make football a better game for all concerned, the Committee said.

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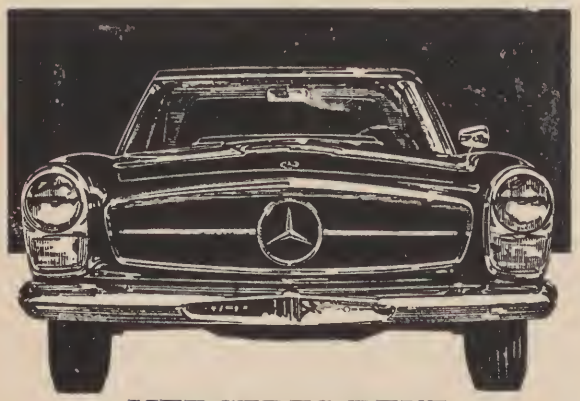
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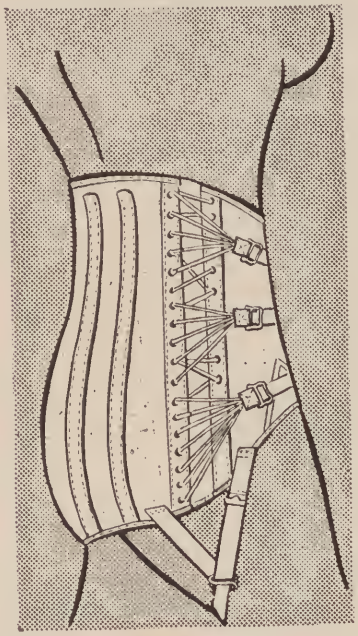
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J. PARRAN JARBOE, MD

J. Parran Jarboe, MD, La Plata, will assume his duties as Councillor from the Southern District at the conclusion of the 1968 Annual Meeting. A graduate of the Georgetown University Medical School in 1942, he interned at Providence Hospital, Washington, DC, following which he undertook graduate training at the Mayo Foundation, Minnesota from 1943 to 1946. He has the Master of Science Degree in Surgery from the University of Minnesota Medical School, and is a Fellow of the American College of Surgeons.

He is Chief of Surgery at Physicians Memorial Hospital, La Plata, has surgical privileges at the principal Washington, DC, hospitals and maintains his Faculty membership through the Charles County Medical Society.

THE HISTORY OF SPECTACLES

Samuel L. Fox, MD. was awarded the Knapp Prize for the best exhibit in Ophthalmology at the 116th Annual Meeting of *AMA* held at Atlantic City in June, 1967.

The exhibit consisted of almost 200 pairs of old spectacles, beginning with forged iron frames of the type worn by George Washington, of the period 1740-1760, and proceeding through the brass, pewter and steel frames of the early 1800's. The small rectangular "Ben Franklin" types as well as the small ovals and octagonals of the 1840's and 1860's were shown, as well as unusual varieties of double hinged lenses (early sunglasses attached to the reading lens frames). The "blued metal" frames of the post-Civil War period and the nickel-plated frames of the late 1800's were also exhibited. Many unusual varieties were



SAMUEL L. FOX, MD

shown: the amber frosted lenses for gunning; the blue lens wire-guard frames used by railroaders to keep cinders out of the eyes; the early splitglass bifocals of the Benjamin Franklin variety; the later paste-on bifocals of the 1890's and numerous models of prince nez and lorgnette eyeglasses were shown.

In addition, reproductions of the earliest eyeglasses known to be in existence were shown: the leather framed eyeglasses belonging to Professor Wilibald Perkheimer in 1500, which are now in the National Museum of Nurenberg, Germany; and the wooden framed spectacles of 1405 belonging to Cardinal von Soest. (Reproduced from his portrait)

Many manuscripts, letters from Benjamin Franklin and Thomas Jefferson, catalogues illustrating early eyeglasses, etchings and drawings, portraits etc. illustrating the early history of spectacles were displayed. The history of spectacles was traced by these historic means.

From New York

Physicians who are unable to attend the convention in Dallas of the American Academy of General Practice, September 18 to 21, will be able to keep right on top of the proceedings by listening to "Doctors Convention Report," which will be broadcast over 10 National Science Network affiliated stations in major cities.

Daily 15-minute broadcasts, morning and evening, from the convention city, will carry summaries of selected clinical papers delivered at the meeting, and interviews with leading speakers. Because the broadcasts will be on open-circuit FM radio, physicians will be able to listen at home, in their offices or in theirs cars.

The National Science Network also produced the "Doctors Convention Report" from the recent *AMA* meeting in Atlantic City, as it did the previous year's *AMA* meeting in Chicago and the *AAGP* convention in Boston.

The first broadcast from Dallas is scheduled for Monday evening, September 18. The following stations will carry "Doctors Convention Report:" *WTOW*, 101.9 FM, Baltimore; *WQAL*, 106.1 FM, Philadelphia; *WNCN*, 104.3 FM, New York.

The National Science Network coverage of the American Heart Association meeting in October in San Francisco. This "Doctors Convention Report" also will be carried over the full 10-station network across the country.

From Washington

The House Ways and Means Committee approved a social security bill including some Medicare and Medicaid changes sought by the medical profession and excluding others opposed by the *AMA*.

The committee also discarded an Administration proposal to extend Medicare coverage to disabled workers under age 65, as well as an Administration-opposed proposal that would have put federal government workers under Medicare. The actions were part of a general scaling down of the increases in social security benefits sought by President Johnson.

A committee bill (H.R. 12080) included these changes in the present law:

—Allow Medicare patients, or doctors, to collect from the government on the basis of an itemized bill. Present law requires a bill receipted as having been paid to the doctor if the doctor doesn't accept an assignment. (*AMA*-supported)

—Authorize states to allow physicians to bill Medicaid patients directly if they are not also cash assistance recipients. (*AMA*-supported)

—Eliminate the requirement for certification by a doctor before admission of a Medicare patient to a hospital. (*AMA*-supported)

—Shift coverage on Medicare outpatient diagnostic services provided by hospitals from Plan A to Plan B. (*AMA*-supported)

—Put limits on federal contributions to states for medicaid programs. Beginning July 1, 1968, the federal ceiling on eligibility would be 150% of the annual income set by a state for welfare eligibility. It would drop to 140% on January 1, 1969, and to 133⅓ per cent January 1, 1970.

—Require states to give birth control information to welfare patients who request it.

In addition to opposing extension of Medicare

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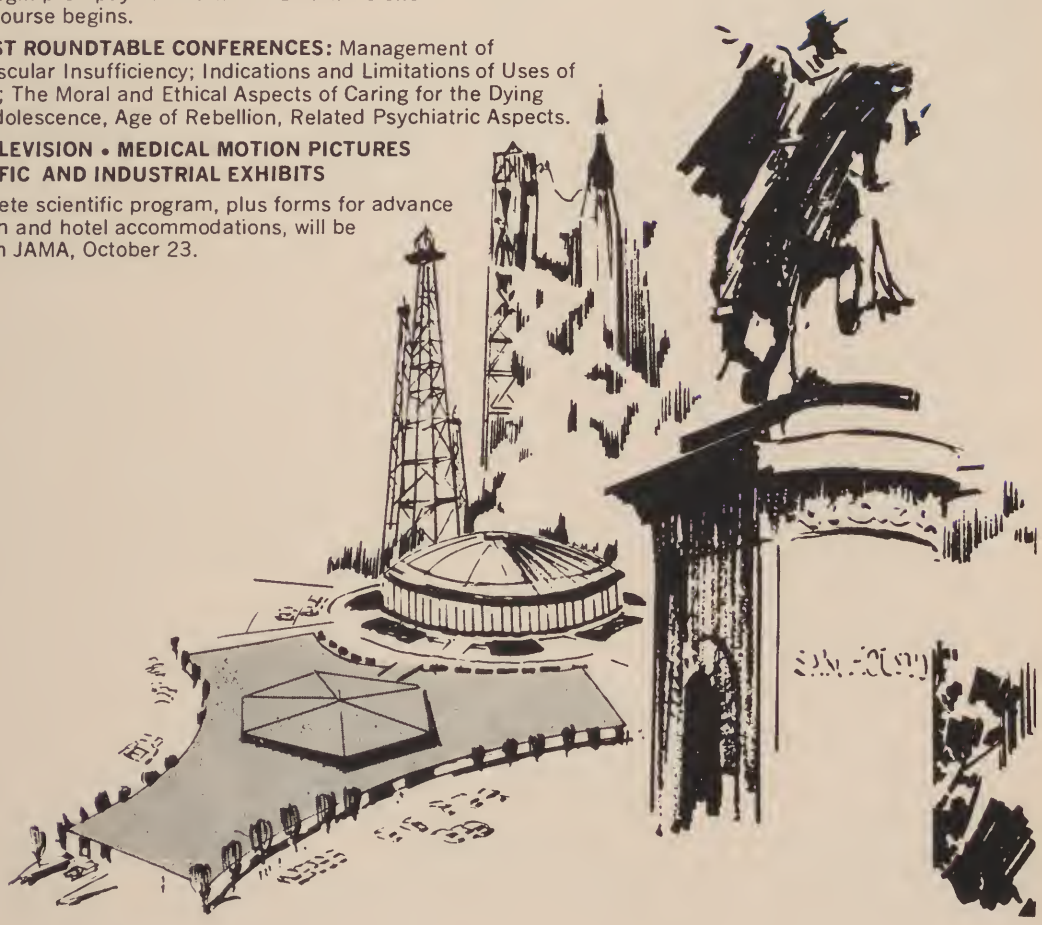
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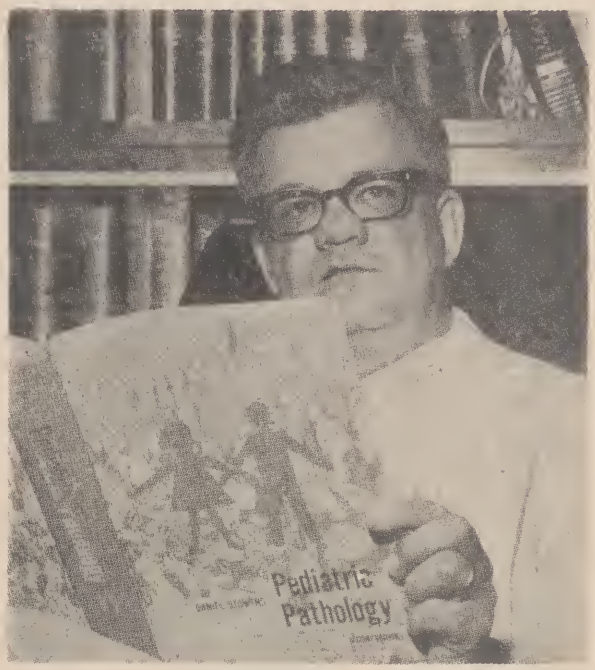
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The complete scientific program, plus forms for advance registration and hotel accommodations, will be featured in JAMA, October 23.



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Dr. Hill will soon be among the more than 300,000 Evelyn Wood Reading Dynamics Institute graduates who have increased their reading efficiency up to 470%.

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- The nonfatiguing flavor and smooth, nongritty consistency of tablets and liquid encourage continued patient cooperation during long-term therapy.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) of liquid contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. **Dosage:** one or two tablets, well chewed or allowed to dissolve in the mouth, or one or two teaspoonfuls of liquid to be taken between meals and at bedtime.

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to disabled workers under age 65, the *AMA* opposed creation of a new Plan C under Medicare and a provision for chiropractor's services—both of which were rejected by the committee.

The House group slashed back the President's proposal for a 15% minimum monthly social security increase in cash benefits to 12.5%. The administration proposal for an increase in social security taxes also was scaled down to 4.4%, on the employer and on the employee, of the first $7,600 in wages starting in 1968. The taxable wage base now is $6,600, and the tax rate is 4.4%. The Administration had asked that the base be increased to $7,800 next year, and in later stages, to $10,800.

* * * * *

The *AMA* and the Kansas City (Mo) Community Blood Bank asked Congress to exempt community blood banks from the anti-trust laws.

Representatives of the groups testified at a senate judiciary subcommittee hearing in support of S.1945 which would amend the anti-trust laws to provide that a nonprofit blood or tissue bank, or hospital, or physician who refuses or who joins together with others in refusing to obtain or to accept delivery of blood, blood plasma, other tissue or organs from any other blood or tissue bank would not be in restraint of trade. The interstate shipment of blood, blood plasma, other tissue or organs also would not be deemed to constitute trade or commerce in commodities.

The legislation was introduced after the Federal Trade Commission ruled that a group of Kansas City pathologists, hospitals and blood bank officials had combined illegally to restrain commerce in human whole blood. An appeal against the ruling is pending in the Federal Eighth Circuit Court of Appeals in St. Louis, Missouri.

Robert S. Mosser, MD, President of the Kansas City Blood Bank, said it was inconceivable that groups of physicians may not have the right to discuss shortcomings of medical practice, including the use of blood and its derivatives.

Frank C. Coleman, MD, Tampa, Florida, pathologist, presented the views of the *AMA*:

> "Because serious health hazards may arise through transfusion by virtue of the medical condition of the donor, the care necessary in the selection of blood donors by blood banking



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facilities cannot be over-emphasized. Serious consequences may arise unless the blood is properly drawn, processed, stored, and distributed. And it is imperative that these procedures be performed under high standards, under the guidance and control of proper medical supervision."

Dr. Coleman pointed out that the *AMA* in 1963 adopted a statement *"to the effect that the transfusion of blood constitutes the transplant of human tissue, and that physicians responsible for transfusions render a medical service to the patient."*

"The House of Delegates stated that the selection of the donor, the drawing of the blood, its processing and storage, the delivery, the typing and crossmatching, and the administration of the transfusion and the evaluation of its effects, were functions intimately involving medical judgment and requiring medical supervision," Dr. Coleman said.

"The *AMA* believes that the health interests of the community are best served when the supply of blood is maintained on a replacement basis. We feel that the patient, the donor, and the public benefit when blood is replaced by the patient, his family, or his friends in the various organizations of which he is a member.

"Since the consequences of any abuses can be tragic, it is our opinion that the physician and hospital must have available to them every means of insuring the safety of the patient."

* * * * *

The Public Health Service reported that, according to Hill-Burton state agencies, 3,327 of the nation's 6,716 general hospitals need modernization or replacement of facilities for 272,000 of their beds. Of the total, replacements are required for 70,000.

But William Stewart, MD, PHS Surgeon General, said that replacement or modernization was not the complete answer.

"Development of alternative care facilities, earlier preventive treatment, increased and more readily available out-patient services—all of these may offer a better solution to a given hospital's problems," he said.

Dr. Stewart said 143 hospitals in the survey were critically overcrowded with average annual occupancy rates of 90 per cent or more of reason-



What can be done for Susan Jane To stop the runs and crampy pain?

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric
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...adsorbs irritants with kaolin, and protects intestinal mucosa.

In children, Parepectolin may be used to control diarrhea promptly and prevent dehydration, until etiology has been determined. In some cases, Parepectolin may be all the therapy necessary.

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Each fluid ounce of creamy white suspension contains:
Paregoric (equivalent)..... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
Kaolin (specially purified).... (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Children's Dose: One or two teaspoonfuls three times daily.

ROER

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New Agreement Provides Nationwide Blood Coverage

A new agreement covering the nationwide exchange of blood and blood credits between the country's major blood banking organizations was announced jointly today by the American National Red Cross and the American Association of Blood Banks.

The agreement, signed by General James F. Collins, president of the *ARC*, and George Hummer, MD, president of the *AABB*, replaces the original agreement which the two organizations developed in 1961, setting up a national reciprocal system to facilitate blood donor replacements and to utilize blood supplies more effectively.

"We welcome this new agreement with the *AABB*," General Collins said. "The two largest blood agencies in the United States, working in harmony, will strengthen and continue to improve our efforts to effectively and promptly meet the increasing blood needs of our countyr."

"The *AABB* is pleased to see this agreement with the *ARC*," said Dr. Hummer. "Member blood banks of the *AABB* are located in all 50 states and the District of Columbia. There is no question that the cooperative program will be beneficial to thousands of donors and patients, and we are confident that many more advantages will accrue as we continue to plan and confer together."

The purpose of the reciprocity agreement is to make possible the exchange of blood and blood donor replacement credits between *AABB* banks and *ARC* regional centers on a national basis as a service and special convenience for patients and donors who do not live in the same community.

For the most part, reciprocity exchanges are a matter of paperwork. Debits and credits posted to the accounts of regional centers and blood banks are coordinated through the *ARC* Central Exchange in Washington, DC and the *AABB* National Clearinghouse Office in San Francisco, and actual blood shipments are made at the end of the month in settlement of any imbalances.

The reciprocity system makes possible also more efficient utilization of perishable blood supplies by enabling the transfer of blood surplus from one bank or center to fill blood shortages in another.

During the six years the original agreement was

able capacity. Another 1,289 hospitals had occupancy rates of between 80 and 90 per cent, "substantially above the national average."

"Any hospital experiencing an average annual occupancy rate of 90 per cent or more exceeds the safe limit," he said.

* * * * *

The *AMA* and the Missouri State Medical Association argued against an *Internal Revenue Service* proposal to tax the advertising revenues of publications of non-profit associations.

Representatives of other affected, non-medical organizations also opposed the proposed tax at an *IRS* hearing.

Bernard D. Hirsh, director of the *AMA's* Law Division, pointed out that the pertinent law on unrelated income had been on the books for 17 years without any such tax being proposed by the government.

"The proposed regulations go beyond the law, first in arbitrarily classifying all advertising contained in trade and professional journals as unrelated, and secondly, in treating income derived from this source as if it were income from a business capable of separate existence," Hirsh said.

Hector W. Benoit, Jr., MD, *MSMA* President, noted that one of the states purposes of the proposal was to eliminate alleged unfair competition in advertising between non-profit association journals and profit magazines.

"If you have the stomach to read many of these advertisements (in Missouri Medicine), you will find they are directed purely to a professional audience and would be unlikely to enhance the public appeal to such lay publications as Atlantic Monthly, Look, etc. . . .," Dr. Benoit said.

He also noted that medical societies furnish many voluntary services for their communities, as well as provide physicians with much of their latest information on medical advances.

"Without the help of the advertising income from these publications and the income of exhibitors at these medical meetings, many of these sources of educational information would be severely restricted, even indeed in many instances, be eliminated entirely," he said.

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Precaution: same as 16 mg. of phenobarbital



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100s, 500s, 5000s

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in effect, more than 600,000 replacement credits and units of blood have been exchanged between the two organizations.

In the United States, over 5,000,000 units of blood are transfused annually, and a steady increase is expected as newer medical and surgical techniques are developed. The majority of these blood needs are collected and processed by the 56 blood centers serving 1,700 chapters of the American National Red Cross and the more than 1,000 hospital and community blood banks belonging to the American Association of Blood Banks.

Members of the negotiating committees were: Mr. Frederic S. Laise, T. J. Greenwalt, MD, Allan S. Chrisman, MD, and Mr. Jack Henry, Washington, DC, representing the *ARC*, and Rosser L. Mainwaring, MD, Detroit, Michigan, O. B. Hunter, Jr. MD Washington, DC, and Mrs. Bernice M. Hemphill, San Francisco, California, representing the *AABB*.

Oral Contraceptives and Their Effects on Metabolism

How do oral contraceptives affect the metabolism of young, middleaged, and older women?

The National Institutes of Health announced today that Victor Wynn, MD., Head of the Alexander Simpson Laboratory for Metabolic Research at St. Mary's Hospital Medical School, University of London, England, has been awarded a $43,120 contract by the National Institute of Child Health and Human Development in Bethesda, Maryland to study the metabolic processes of women who take oral contraceptives.

Dr. Wynn will investigate the effects of oral contraceptives on carbohydrate, intermediary, and lipid metabolism to see whether changes produced are detrimental to the health of the women taking these drugs.

Preliminary studies by Dr. Wynn have indicated impaired carbohydrate metabolism—with symptoms suggestive of diabetes—in some women taking oral contraceptives. He has also found changes in lipid (fatty substance) metabolism and distribution which might be linked to atherosclerosis.

Although direct relations between metabolic problems and oral contraceptives have not been established, preliminary evidence indicates a need for a careful study of this relationship.

Under the terms of this contract, Dr. Wynn will begin a series of metabolic studies designed to follow a group of women over a long period of time to determine the effects of these drugs. He will study metabolism of women before taking the drugs, and during administration of the drugs. In addition, older women will be studied to determine effects of oral contraceptives on metabolism before and after menopause

About 1,000 women will take part in this study—500 women in the test group and 500 women using other contraceptive methods to serve as a normal comparison group. The women will be recruited from those being cared for by private practitioners and family planning clinics.

In addition to the general studies of metabolism, Dr. Wynn will conduct more detailed biochemical studies of some of the intermediate chemical reactions in metabolism (intermediary metabolism) to identify specific mechanisms of action of these drugs. As part of this detailed investigation, he will study several small groups of women with different metabolic problems. These will include women with diabetes, Cushing's disease, obesity, and those receiving hormone therapy for other problems. About 300 women will take part in this aspect of the study.

* * * * *



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Dry Eczema	Acne
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Dry Skin	Diaper Rash
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Insect Stings	Hemorrhoids

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New remedies containing antibiotics have been tested, but have often caused side effects which are worse than itching skin. After many years of research and testing, **Resinol Greaseless Cream** was developed. . . . A doctor's formula containing safe yet powerful ingredients, **Resinol Greaseless** contains an amazing, proven "anti-itch" medication called Resorcin, which quickly and effectively relieves most any kind of itching. Try **Resinol Greaseless** . . . You'll be delighted to find that it really works! At all drug stores. Buy a tube today.

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VALIUM® (diazepam) Roche®

Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Infants, patients with history of convulsive disorders, glaucoma or known hypersensitivity to drug.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly or debilitated patients (not more than 1 mg, one or two times daily initially) to preclude ataxia or oversedation, increasing gradually as needed or tolerated. As is true of all CNS-acting drugs, until correct maintenance dosage is established, advise patients against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. If such combination therapy is used, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants. Advise patients against simultaneous ingestion of alcohol or other CNS depressants. Safe use in pregnancy not established. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances, acute hyperexcited states, hallucinations); changes in EEG patterns during and after drug treatment. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms (convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Dosage—*Adults:* Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. *Geriatric patients:* 1 or 2 mg/day initially, increase gradually as needed and tolerated. (See Precautions)

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 50 and 500.

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(Warning: butabarbital may be habit-forming.)

Numa Dura-Tabs provide *prolonged* three-way action to ease breathing. Theophylline, a potent bronchodilator with minimal effect on the CNS, opens air passages and reduces bronchial spasm. Ephedrine HCl improves breathing capacity through its decongestant action. Butabarbital, a mild sedative, allays fear and apprehension.

Dosage: One Numa Dura-Tab every 8 to 12 hours helps keep the asthmatic patient symptom-free all day/all night.

Precautions: Use with caution in cardiovascular or hyperthyroid disease, severe hypertension, circulatory collapse, prostatic hypertrophy, or glaucoma.

Night Leg Cramps . . . Unwelcome Bedfellow

In Diabetes[1], Arthritis[2], and Peripheral Vascular Disorders[2]



now . . . specific therapy for night leg cramps

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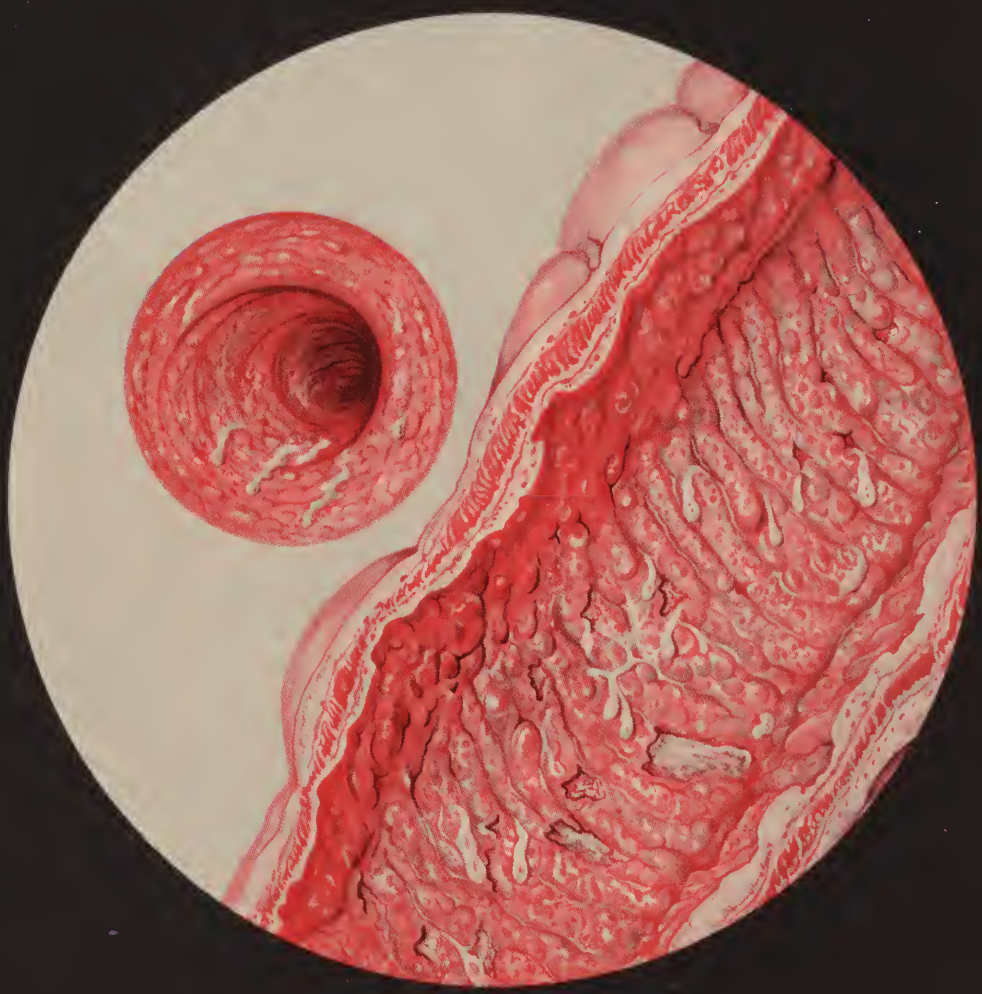
Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.[3] Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.

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References: 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rawls, W., et al.: Med. Times, 87:818, 1959.
6/67 Q-706A

even in ulcerative colitis...

characterized by:
— diarrhea, cramps, tenesmus
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Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . . 0.025 mg.

controls diarrhea

In six published studies[1-6] detailed results are given on the use of Lomotil in 111 patients with chronic ulcerative colitis. They show that Lomotil gave satisfactory to "excellent" control of diarrhea in more than two-thirds of these patients. As the disorder advances and destroys bowel musculature, the motility-lowering action of Lomotil, understandably, has less effect.

The successful use of Lomotil in a disorder as exceedingly difficult to treat as moderate ulcerative colitis emphasizes again its unsurpassed antidiarrheal effectiveness in these more common conditions:

- **Gastroenteritis**
- **Acute infections**
- **Spastic colon**
- **Drug induced diarrhea**
- **Functional hypermotility**

For correct therapeutic effect
Rx correct therapeutic dosage

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are:

Children: Total Daily Dosage

3-6 mo. . . ½ tsp.*t.i.d. (3 mg.)
6-12 mo. . ½ tsp. q.i.d. (4 mg.)
1-2 yr. . . . ½ tsp. 5 times daily (5 mg.)
2-5 yr. . . . 1 tsp. t.i.d. (6 mg.)
5-8 yr. . . . 1 tsp. q.i.d. (8 mg.)
8-12 yr. . . 1 tsp. 5 times daily (10 mg.)
Adults: 2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.

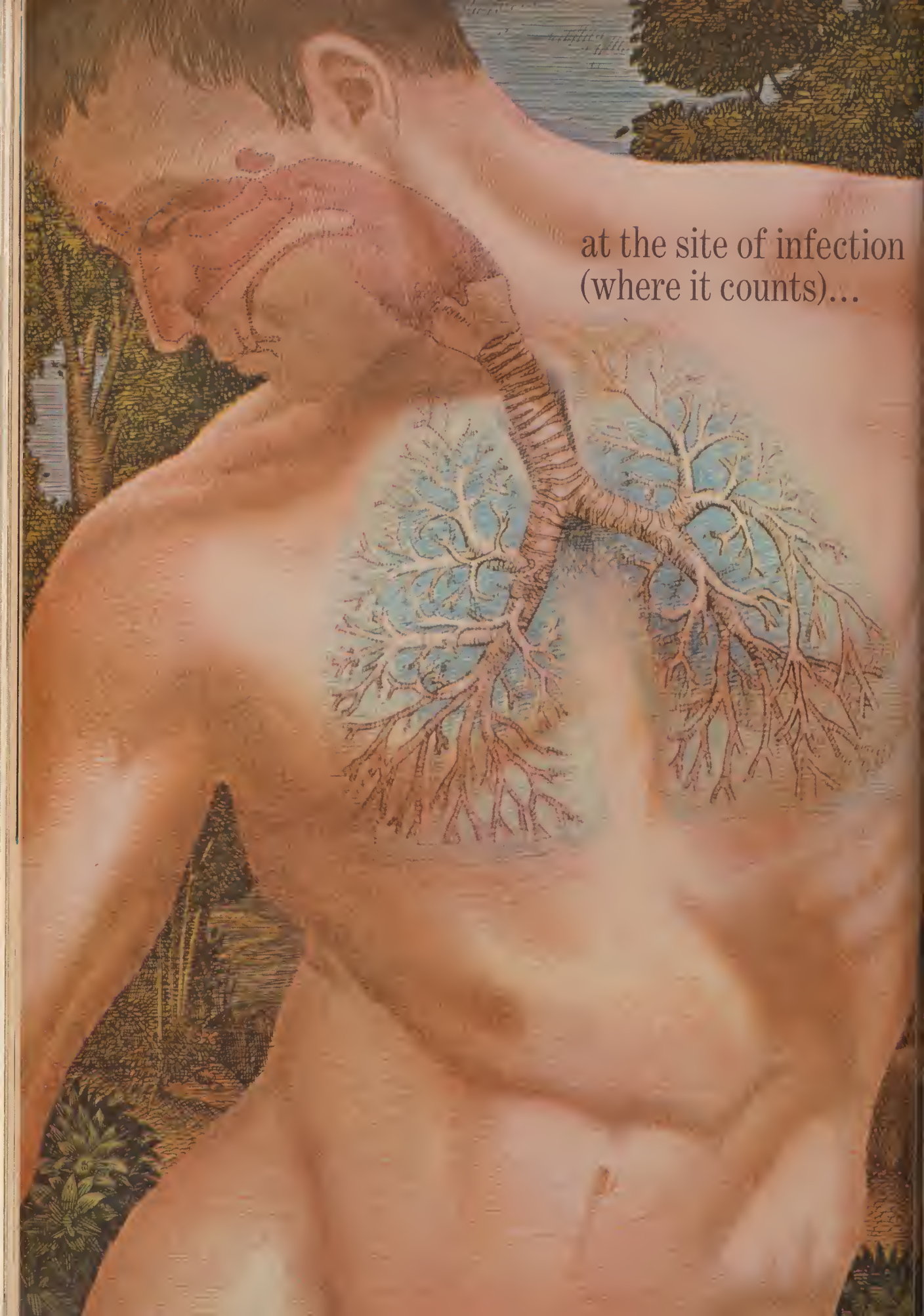
*Based on 4 cc. per teaspoonful.
Maintenance dosage may be as low as one-fourth the initial daily dosage.

Precautions: Lomotil is a federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and tachycardia. Lomotil should be used with caution in patients with impaired liver function or those taking addicting drugs or barbiturates.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of the extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

1. Barowsky, H., and Schwartz, S. A.: J.A.M.A. *180*:1058-1061 (June 23) 1962. 2. Cayer, D., and Sohmer, M. F.: N. Carolina Med. J. 22:600-604 (Dec.) 1961. 3. Hock, C. W.: J. Med. Ass. Georgia 50:485-488 (Oct.) 1961. 4. Van Derstappen, G., and Vandenbroucke, G.: Med. Klin. 56:962-964 (June 2) 1961. 5. Merlo, M., and Brown, C. H.: Amer. J. Gastroent. 34:625-630 (Dec.) 1960. 6. Weingarten, B.; Weiss, J., and Simon, M.: Amer. J. Gastroent. 35:628-633 (June) 1961.

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Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have also been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Adverse Reactions: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have developed in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly, usually within forty-eight hours, if the drug is readministered to sensitive patients. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appea be definitely related to use of the drug, laboratory findings characterized by increased direct-reacting bilirubin, el alkaline phosphatase levels, negative or weakly positive ce flocculation and thymol turbidity tests, elevated serum glu oxalacetic transaminase levels, peripheral eosinophilia, an mal cholecystograms.

Individual idiosyncrasy seems evident since jaundice h been reported in other patients taking prolonged courses medication. Patients with chronic infection have been give to 2 Gm. of the drug daily for periods of two to six month patients with rheumatic fever have taken prophylactic do 0.5 Gm. daily for two years without difficulty. In one gr 144 patients who received the drug daily for two years, no dice was noted. It was of interest that members of six of patients' families, who were not taking the drug, had ep of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels determined in a group of fifty-four adults and children wh 250 mg. of Ilosone daily for an average of sixteen mon rheumatic fever prophylaxis. The results were compare those of a similar group of forty-four patients who receive icillin. There were no cases of jaundice in either group. Ele of SGPT and serum alkaline phosphatase levels during the of treatment was observed in one patient treated with I and in two patients treated with penicillin. Seven other pa in the group receiving Ilosone and four others in the pen group showed elevations in one of the tests at some time d administration of the drugs.

Very satisfactory therapeutic results, without toxicity, reported in 102 pediatric patients who received short-term day) courses of Ilosone in the treatment of streptococcus tions. Results of liver function tests in these patients comparable to those in a similar control group who had re penicillin.

Gastro-intestinal disturbances not associated with hepa fects are observed in a small proportion of individuals as a of a local stimulating effect of the medication on the alime tract; however, the normal intestinal gram-negative bac flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with th of erythromycin, there have been occasional reports of urti skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orally

Ilosone Pulvules®, Ilosone Liquid 125, Ilosone, 125, for Suspension, Ilosone Drops, Ilosone Chewable Tablets.

For infants and for children under twenty-five pounds o weight, the usual dosage is 5 mg. per pound every six hour children twenty-five to fifty pounds, 125 mg. every six h (Tablets Ilosone Chewable should be chewed or crushed swallowed with water.)

For adults and for children over fifty pounds, the usual d of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythro therapy should be considered.

In the treatment of syphilis, the recommended total dos 20 to 30 Gm. given in divided doses for a period of ten to fi days. Close follow-up of the patient is necessary since ery mycin drugs have not had adequate evaluation in all stag syphilis. Examinations of spinal fluid are recommended a of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four day recommended. In the treatment of gonorrhea, patients w suspected lesion of syphilis should have a dark-field examin before receiving antibiotics, and monthly serologic tests s be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and 25 (equivalent to base), in bottles of 24 and 100.

Ilosone Liquid 125, Oral Suspension, U.S.P., 125 mg. (equiv to base) per 5-cc. teaspoonful, in 60-cc. and pint-size pack

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equiv to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size packs

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 10-cc packages, with dropper calibrated at 25 and 50 mg.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to b in bottles of 50. [0

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SOURCE: DUNCAN, G.G.: SCIENCE NEWS LETTER, 83:403 (JUNE 29) 1963.

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ACCORDING TO THE NEW YORK TIMES OF APRIL 13, 1890, THE DEFEAT OCCURRED BECAUSE HE FAILED TO CHECK HIS INTELLIGENCE INFORMATION. "IT WAS A MATTER OF MERE INDOLENCE AND THIS INDOLENCE WAS CAUSED BY FAT."

SOURCE: JAMA 186:65 (OCT. 5) 1963.



THE BOOK *"PRAY YOUR WEIGHT AWAY"* URGES READERS TO ASK GOD TO HELP YOU LIKE EXERCISE" FOR 15 MINUTES A DAY.

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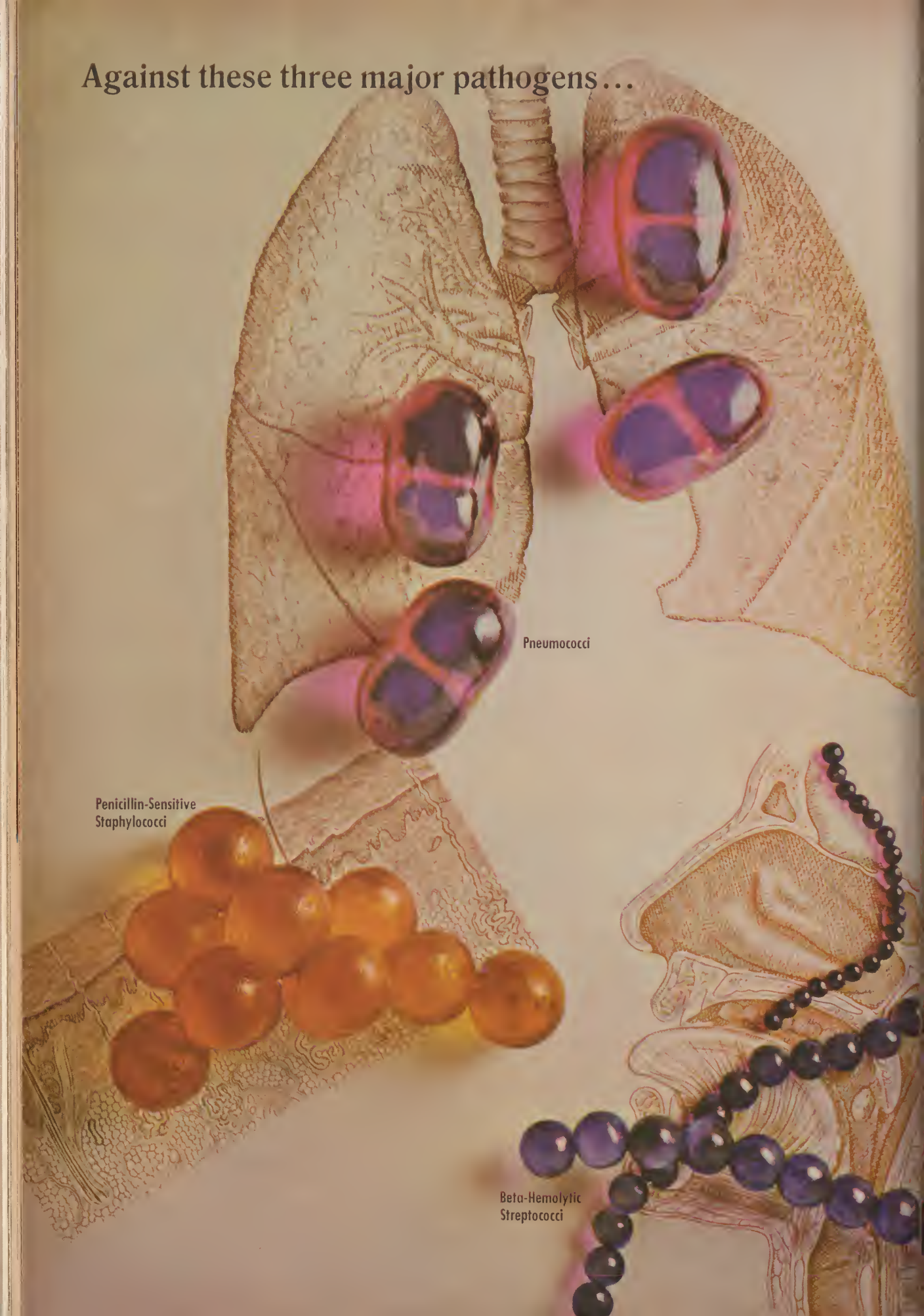
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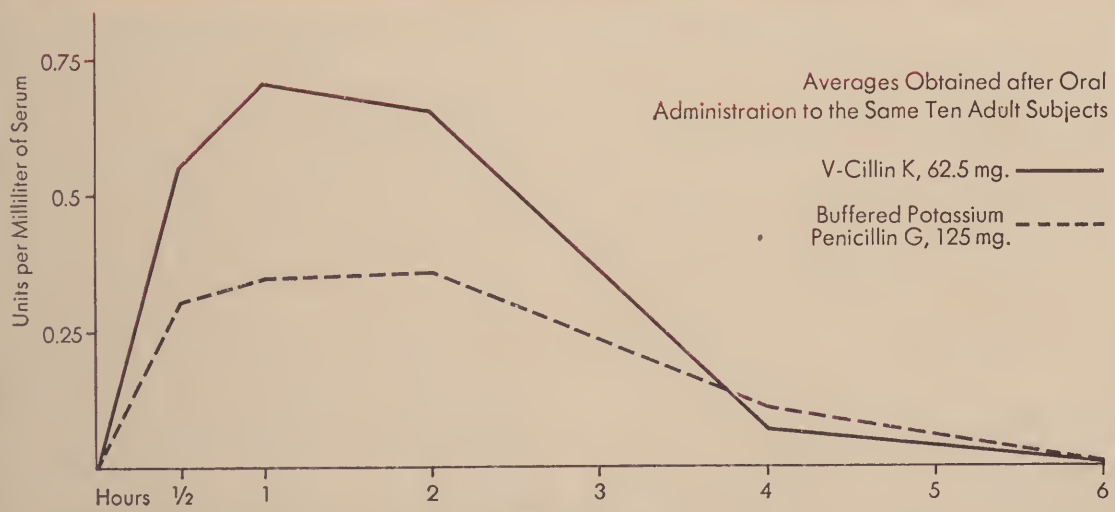
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Antibiotic	Staph. Aureus (Penicillin-Sensitive) MIC (mcg./ml.) Median	Range	Streptococcus, Group A MIC (mcg./ml.) Median	Range	Diplococcus Pneumoniae MIC (mcg./ml.) Median	Range
Penicillin V	0.02	0.02-0.04	0.02	0.003-0.4	0.01	0.005-0.2
Penicillin G	0.02	0.005-1.6	0.005	0.002-0.2	0.02	0.01-0.1
Methicillin	1.6	0.4-6.3	0.2	0.1-0.4	0.2	0.1-1.6
Oxacillin	0.4	0.1-3.1	0.04	0.02-0.4	0.1	0.04-0.8
Cloxacillin	0.2	0.2-0.8	0.1	0.1-0.8	—	—
Nafcillin	0.4	0.2-0.8	0.04	0.02-0.1	0.02	0.02-0.2
Ampicillin	0.2	0.1-0.8	0.02	0.01-0.04	0.02	0.01-0.04

Adapted from Klein, J. O., and Finland, M.: New England J. Med., 269:1019, 1963.

with high blood levels, even in the presence of food



Adapted from Griffith, R. S., and Black, H. R.: Current Ther. Res., 6:253, 1964.

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(See next page for prescribing informatic

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Description: V-Cillin K is the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly). This chemically improved form combines acid stability with immediate solubility and rapid absorption. Higher serum levels are obtained more rapidly with this penicillin than with equal oral doses of penicillin G. The higher serum levels and acid stability of V-Cillin K make it a more dependable penicillin for oral use.

V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

Indications: V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Warnings: In rare instances, the use of penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin and in those with bronchial asthma or other allergies. Resuscitative drugs should be readily available for emergency administration. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for relief of immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with parenteral dosage schedules, frequent evaluation of the renal hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory stu (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowt pencillin-insensitive organisms. In such cases, its administration sh be discontinued, and appropriate measures should be taken.

Adverse Reactions: Although serious allergic reactions are much common with administration of oral penicillin than with intramus forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it does possess a sig cant index of sensitization. The following hypersensitivity react associated with the use of penicillin have been reported: skin ra ranging from maculopapular eruptions to exfoliative dermatitis; caria; and reactions resembling serum sickness, including chills, fe edema, arthralgia, and prostration. Severe and often fatal anaphy has occurred (see Warnings). Hemolytic anemia, leukopenia, th bocytopenia, and nephropathy are rarely observed side-effects are usually associated with high parenteral dosage.

Administration and Dosage: For Tablets V-Cillin K and for V-Cill Pediatric, the usual dosage ranges from 125 mg. (200,000 units) t times a day to 500 mg. (800,000 units) every four hours. For infe the daily dosage may be 50 mg. per Kg. of body weight divided three doses.

Beta-hemolytic streptococcus infections without associated teremia may be treated with 200,000 to 400,0000 units three time day. Therapy should be continued for a minimum of ten days to pre development of rheumatic fever and/or other serious complicati Dosage for routine streptococcus prophylaxis in patients with a his of rheumatic fever or congenital heart disease may be 200,000 u once or twice daily. When such patients undergo tonsillectomy, t extraction, or other minor surgery, the prophylactic dose should 500,000 units every six hours given two days prior to surgery and two days postoperatively. If oral medication is not feasible on the of surgery, parenteral therapy should be considered. Mild to mo ately severe pneumococcus pneumonia has been treated effecti with 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be g every six to eight hours in conjunction with indicated surgical pr dures.

For gonorrhea in males, 500 mg. (800,000 units) every four hours three doses may be employed; in females, 500 mg. every four h for six doses are recommended. Refractory infections generally resp to a second treatment three to four days following completion of first. Treatment of gonorrhea with severe complications should individualized, with prolonged and intensive treatment. Patients wi suspected lesion of syphilis should have a dark-field examination fore receiving penicillin and monthly serologic tests for a minimu three months.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units) bottles of 50 and 100; and 250 mg. (400,0000 units) and 500 (800,000 units), in bottles of 24 and 100.

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 units) 5 cc. of solution, in 40, 80, and 150-cc.-size packages. [032

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

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CONGENITAL ABSENCE OF THE GALLBLADDER AND CYSTIC DUCT CASE REPORT

SAMUEL R. PINES, MD FACS
and
MAURICE FELDMAN. Jr., MD

During daily surgical practice, one frequently encounters congenital anomalies which are described in the medical texts. But the occurrence of a rather rare anomaly in an adult causes one to inquire from his fellow physicians, review the literature, ponder the facts, and then report the unusual finding. A recent case of congenital absence of the gallbladder and cystic duct in an adult was noted and is described with the hope that this experience may be instructive to all physicians, especially those performing surgery.

Case Report

This 59 year old white female was admitted 21, Feb. 1965, to the South Baltimore General Hospital for an elective cholecystectomy. Approximately two months prior to admission, the patient was seen by her physician (M.F.) because of an episode of right subcostal pain. There was no history of previous surgery, no intolerance to any specific foods, jaundice was never noted, and a complete medical review was normal except for moderate obesity. The hemogram, liver function tests, and an intravenous pyelogram were all entirely normal. Two separate gallbladder visualization and function roentgen studies repeated twice with double doses of Telepaque did not outline the gallbladder and were reported as a "non-functioning gallbladder in the absence of liver disease."

Following this, the patient underwent a laparotomy for the proposed cholecystectomy and, unfortunately, without prior positioning of a cassette holder. After entering the peritoneal cavity via a right subcostal incision, a thorough search of the right upper quadrant revealed no evidence of the gallbladder. Instead, a small fibrous cord-like structure about 1.5 cm. long and 0.3 cm. diameter led from the area of the quadrate lobe of liver directly to the second portion of the duodenum. During the exploration, the duodenum was inadvertently opened at the junction of the cord-like structure and this opening was utilized to explore the duodenum. The rent was closed later. Further dissection in the proximal area of the duodenum and stomach revealed no evidence of any gross abnormalities of these structures. Dissection of the porta hepatis area outlined a normal right and left hepatic duct forming a normal common hepatic duct, a normal hepatic artery and portal vein. The common hepatic duct was about 0.8 cm. diameter, thin walled, and was not attached to any other structure but led directly and entered independently into the first portion of the duodenum. No stones were palpable and needle aspiration of the hepatic duct revealed clear, yellow, golden bile. This could also be ascertained by milking distally the common hepatic duct and noting the clear, yellow bile via the rent in the duodenum. Because of the benign clinical history, absence of

jaundice, and the normal extrahepatic biliary ducts, no effort was made to implant a tube in the common hepatic ducts. Instead, the decision was made to schedule an intravenous choledochogram at a later date. The abdominal wall was closed in layers.

The postoperative course was uneventful but the intravenous choledochogram unfortunately failed to visualize the biliary ducts. The patient was discharged from the hospital and has remained asymptomatic.

Embryology

According to Arey[1] and Gross[2] from the foregut of the 3 mm. embryo just distal to the stomach, the floor of the future duodenum gives rise to a sacculation or hepatic diverticulum which is hollow. This enlarges to form (a) a cephalad portion of glandular tissue which will become the liver and hepatic bile ducts and (b) a caudal portion which becomes the gallbladder and cystic ducts. This latter outpouching, originally hollow, undergoes changes so that it becomes a solid cord structure at age of 5 mm. embryo. As the embryo enlarges to about 7 mm., the solid cord structure develops a lumen which forms the gallbladder and cystic duct. Bile secretion is noted in the 3 month old fetus. Thus the development of the gallbladder and cystic duct is related but separate from the liver and hepatic ductal system.

Incidence

The congenital absence of a gallbladder and cystic duct is an extremely rare condition. Monroe[3] in 1959 performed an extensive survey of autopsy material and collected 181 cases in 1,352,000 autopsies (or about 1:7500), with a large percentage occurring in the newborn—many associated with other congenital abnormalities. In the newborn the occurrence of this anomaly in either sex occurred equally but in the adult, the anomaly was noted twice as frequently in the female. Gross[2] in 1936, reviewed 38 cases of this condition and in 1942, Finney and Owen[4] presented 2 of their own cases, reviewed the literature and totaled 46 cases of this abnormality in adults. Since then a number of authors[5-22] have reported approximately 26 new cases noted clinically, plus this reported case, bringing the total to 73 cinical reported cases. In the same review[5-22] 14 new cases were noted at autopsy and this resulted in a total of 195 autopsy cases. There probably are many others who have noted this abnormality but who unfortunately have not reported this in the literature.

Discussion

The problems associated with the congenital absence of the gallbladder and cystic duct are numerous and varied. A correct preoperative diagnosis is virtually impossible at present. Though this is a rare finding in the adult, clinical symptoms may tend to direct the physician to perform X-ray studies of the gallbladder. In all reported clinical cases, the radiologist reported a nonvisualization of the gallbladder which was interpreted to be pathognomatic of gallbladder disease if no associated liver disease was present.

At the time of surgical exploration, one must make certain to exclude abnormalities of the pancreas, stomach, duodenum and common hepatic bile duct. A patient who has a history or evidence of clinical jaundice, or shows any evidence of abnormality of the bile duct in size wall thickness or bile contained in the lumen, should have a thorough exploration of the main bile channel. This may include a needle choledochogram at time of surgery or insertion of a catheter or T-tube to be performed at time of surgery or at a later date. The procedure of using an endoscope may also be employed at time of surgery.

In this case, the absence of definite clinical symptoms and the grossly normal common hepatic duct did not warrant or justify further duct exploration—other than needle injection which I was not able to perform since no cassette holder had been positioned prior to surgery.

In reviewing the reported cases, approximately half had some abnormality of the common hepatic duct and in these, biliary calculi were found. Intriguingly, even though the gallbladder was absent, many of the reported cases had no compensatory dilatation or enlargement of the common hepatic duct. In discussions involving biliary surgery, one frequently hears that the common duct compensates by enlarging and dilating following the surgical removal of an abnormal gallbladder.

The findings of many, in which there is a congenital absence of the gallbladder and cystic duct with a normal calibre hepatic duct tend to minimize the idea of compensatory dilatation—unless there remains unrecognized pathology.

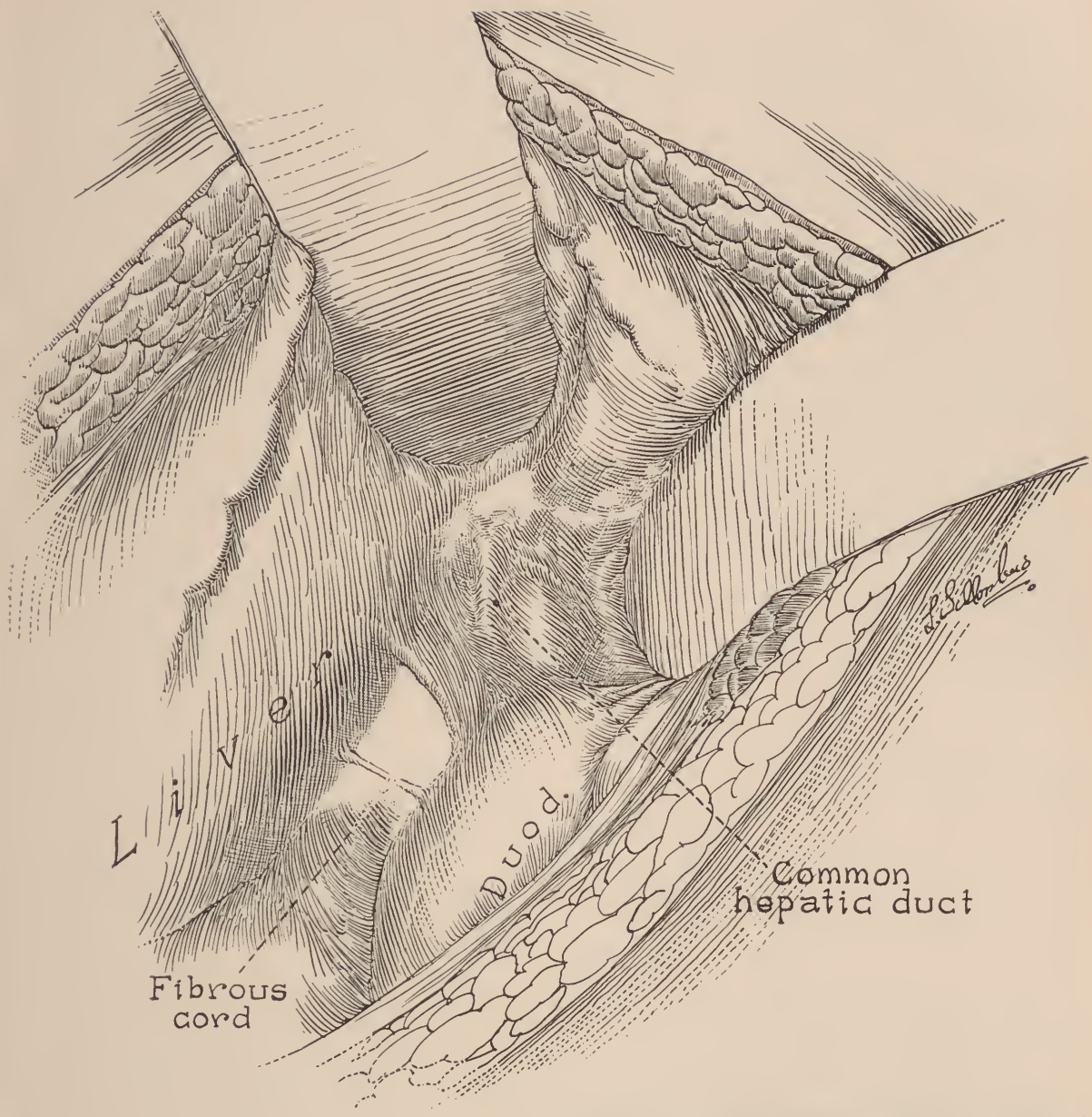


Illustration demonstrating operative findings of absence of gallbladder and cystic duct; fibrous cord from liver to duodenum; normal hepatic bile ducts.

Thus, when the gallbladder is absent, an abnormal common hepatic duct also warrants ductal exploration.

Summary

In the present era of space medicine, of computer diagnosis, of electronic monitoring and nursing, of vital organ replacement, the congenital absence of a gallgladder and cystic duct in an adult does not seem a major significance. Unfortunately, possibly because of the rarity of this condition, all reported cases were diagnosed only by laparotomy. Many cases may have abnormal common ducts which require further exploration, but if one is certain of the presence of the normal extrahepatic ducts no further academic investigation is required for the remaining ductal system may be unnecessarily traumatized.

This case is presented as a reminder to all

physicians that a radiological report of a "non-visualization of the gallbladder" may also infer the absence of a gallbladder and this abnormality may plague them also.

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THE COUNTY MENTAL HEALTH CENTER AND ITS ROLE IN COMMUNITY PSYCHIATRY

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Great strides in the treatment of mental illness have been made during the past decade. Before that time, most mental hospital patients could expect to spend the rest of their lives in the confines of an institution. With the introduction and widespread use of the phenothiazines (Mellaril) and antidepressants, which restored many of these patients to a useful life in society, also came a new wave of hope. Mental hospitals became active treatment facilities rather than custodial institutions, with intensive treatment serving as a means of effecting short-term hospitalization. More striking has been the development of outpatient treatment as a means of forestalling hospitalization of patients, even those with major mental disorders.

A major step in this direction was the establishment of community mental health centers encompassing a range of services needed to combat mental illness. These centers have helped to break down the barriers between the hospital and the outside community through the use of transitional facilities as well as consultative and emergency services.

There are several county mental health centers in Maryland, such as Ann Arundel County Mental Health Center located on its grounds of the Crownsville State Hospital, Baltimore County psychiatric Day Center at Sparrows Point, Maryland and Prince George's County Mental Health Center presently being developed at Cheverly, Maryland. These are prime examples of efforts to develop community mental health centers designed to serve the psychiatric needs of the residents of the county. Circumstances may affect the nature of their design, but in their most complete form, they provide comprehensive care and continuity of treatment for the mentally ill through all stages of the disease, thus assuring each patient the type of care best suited for his condition. The following guidelines express the philosophy of such centers:

(1) The mentally ill, like those suffering from any other kind of illness, need a complete range of services;
(2) Any person eligible for service within any one element of the center is also eligible for treatment within any other;
(3) Transfer of patients among the various elements of the center can be effected without delay when indicated by clinical needs, eg, a patient in the day or night hospital can be admitted as an inpatient, or vice versa;
(4) The information obtained within one element is made available to those responsible for that patient's treatment within any other element.

The services through which these goals are achieved include:

Inpatient Service

This is designed to provide intensive treatment for patients requiring full-time hospitalization. Some patients, especially the agitated and violent or the suicidal and depressed, are admitted directly from the community while others are transferred from the day hospital or the outpatient service. The treatment program embraces psychotherapy, electroconvulsive therapy, occupational and recreational therapy as well as chemotherapy. Patient participation in hospital activities is encouraged and special emphasis is placed on the prevention of aimless loitering in the dormitories.

Partial Hospitalization Service

The partial hospitalization service consists of two separate facilities, a day hospital and a night hospital, each with a specific function.

The Day Hospital accepts patients referred by family physicians, private practice psychiatrists or one of the other elements of the Center, eg, the consultation service. Patients come from their homes in the morning, spend the day participating in group and individual activities and therapy, and return in the evening to spend the night with their families.

Admission to the day hospital avoids the stigma often associated with mental hospitalization, since the patient remains in his home environment. Involving the entire family in the treatment program prevents the abdication of responsibility which too often results in total abandonment of the patient. The day hospital has also fostered better understanding and acceptance of the mentally ill within the community by demonstrating that such people can be treated successfully on an outpatient basis.

All treatment modalities are available to patients on the partial hospitalization service, including group psychotherapy, chemotherapy and a therapeutic milieu. While each is important and indispensable, it is pertinent to note that drugs have made possible the entire concept of partial hospitalization by enabling patients to carry on many of their everyday activities while undergoing psychiatric treatment.

The Night Hospital is designed for patients who find the one-step transition from full-time hospitalization to full-time community living too burdensome. In this facility, patients go to work during the daytime, but return to the hospital in the evening for night programs and treatment activities. They sleep in the hospital and return to their jobs the next day. This continues until a patient improves sufficiently to be returned to the community. The success of the night hospital program is reflected in the reduced number of relapses and the prevention of many of the re-admissions that used to occur soon after discharge.

Emergency Service

The emergency service team consists of a psychiatrist, social worker and registered nurse, one or all of whom make home visits to those disturbed individuals who refuse to go to the Mental Health Center or to their family physician. One of their prime functions is to enlist the cooperation and help of the family to complement the available resources for total treatment. The emergency team also makes follow-up visits on patients who drop out of other treatment programs.

Consultation Service

This is perhaps the most important service available to the general practitioners, clergymen and welfare agencies of the County. Patients referred by them can be admitted to any of the elements of the center. After treatment these patients are returned to the care of the family physician. Clergymen, especially, are encouraged to refer cases for evaluation and treatment since it has been found that almost half of the mentally disturbed patients first go to their clergyman for help.

Outpatient Service

The outpatient service provides follow-up care to patients discharged from the inpatient or partial hospitalization services. Clinics are conducted regularly in several locations within the county, where patients receive both psychotherapy and chemotherapy. Appointments are scheduled at one-to-four week intervals, depending on the needs of the individual. Patients missing their appointments are contacted by one of the staff members or by emergency service personnel.

Treatment

Recognizing the importance of environment as an indispensable element of treatment, the milieu has been designed to enhance other treatment modalities on both the full-and part-time hospitalization services. Cheerful surroundings and staff empathy promote a healthy attitude while adequate recreational facilities combat boredom. Group psychotherapy and occupational therapy are additional methods employed in an effort to promote rapid rehabilitation and to prevent regression.

Psychotropic drugs play an important role in the management of patients at the center. The type of drug used, as well as its dosage, varies with the condition of the patient and with his hospital status.

In depressed patients, good results have been obtained with imipramine (Tofranil). Treatment is started with 25 mg. 3 times a day, then dosage is adjusted as needed. The phenothiazines have

been our most dependable agents for the treatment of both neurotics and psychotics. Experience with many of these has demonstrated the superiority of thioridazine (Mellaril) which we have found to be highly effective and, most important, well-tolerated.

Treatment with thioridazine is started with 25 to 50 mg. two or three times daily, depending on the severity of presenting symptoms. Thereafter, dosage is increased gradually until maximum benefit is obtained. This method obviates drowsiness, an especially important consideration for patient in the day hospital. The absence of extrapyramidal symptoms with thioridazine, even with doses as large as 300 mg. per day, has been noteworthy, and represents a major contribution to more effective management of the mentally ill.

One of the most important points we have learned about the psychotropic drugs is that they must be taken regularly to maintain optimum benefit. Questioning of outpatients not benefitting from the drug usually elicits the information that they take a pill only when they feel "ill" with the expectation that this will yield immediate relief from their problems—somewhat like the effect of an aspirin tablet for headache. Such a view is naive and inimical to their best interests, which are best served by taking their medication daily and without fail. This requires constant repetition and the wholehearted support of the family, for the rewards of maintenance are too striking to be thwarted by lack of cooperation.

Regression and relapse after initial improvement are also related to deviation from patterns of treatment, notably to inadequate dosage. Many of the patients referred to us are taking psychotropic drugs prescribed by their family physician, though apparently without the desired benefit. In many instances, we find that simply increasing dosage produces rapid amelioration of symptoms.

Uncertainty in using drugs such as the phenothiazines is unwarranted, for adequate doses of these drugs are not only well tolerated by disturbed patients, but are also absolutely essential to their welfare. The extensive use of these agents during the past decade has resulted in the accumulation of a wealth of experience providing a useful perspective between wanted and unwanted effects. The latter have been so well identified as to make rationalization in the use of these compounds self-defeating. The family physician is especially well-qualified to prescribe them to greater advantage for he enjoys the confidence of patient and family. A regimen of gradually increasing dosage enhances toleration, a factor which is reassuring to both patient and physician.

This has been especially evident in the use of thioridazine in a starting dose of 25 mg. two to three times daily. This is increased by similar progressive increments until the symptoms are brought under control. Dosage so attained should be continued for several months. Gradual reduction in dosage may then be attempted, but if symptoms recur, dosage should be restored immediately to the previous levels. It is far better to maintain proper therapy in adequate dosage than to risk relapses which make for increased difficulties in management. If digitalis (Digitora) is essential for the patient with heart failure or insulin (Iletin) for the diabetic, then the psychoactive drug is likewise necessary and desirable for the patient with a mental disorder.

A tendency to reduce dosage after the patient is discharged from a mental hospital is to be decried. The patient has been stabilized on a maintenance dose considered optimum and unwarranted reduction may nullify the benefits obtained. In fact, the re-adjustment to living in the community can be a period of heightened stress requiring more, rather than less, drug.

The family physician occupies a strategic role in which he can complement and enhance the worth of the treatment programs instituted by the Center. Proper diagnosis and early use of the appropriate psychotropic drug in therapeutic doses may suffice to maintain the patient in the community and prevent progression of the illness and possible hospitalization. On the other hand, recognition that such therapy can maintain the improved status of the discharged patient will serve to keep that individual within the community, and conceivably, as a useful member.

Summary

The county mental health center, through its several elements, provides a wide range of psychiatric services to county residents. Its facilities and treatment methods aim toward maintaining the mentally ill patient as a useful member of society, an endeavor which non-psychiatrics can complement through proper recognition of the role and use of psychotropic drugs.

ABNORMAL UTERINE BLEEDING

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The presence of irregular uterine bleeding, exclusive of pregnancy, without pain or a palpable tumor remains a persistent problem in women of every age group. In an attempt to arrive at some of the causes of dysfunctional bleeding, investigation has proceded along the lines of endocrine imbalance, iron deficiency anemia, blood dyscrasia, and the detection of unsuspected malignancy.[3,5-8,10]

For many years the necessity for operative removal of the uterus which macroscopically or microscopically showed no evidence of disease has been the concern of the gynecologist. Where preservation of the childbearing function is important, the problem is greater. The reluctance to perform a hysterectomy under the latter circumstances is understandable. Such enigmatic considerations as the frequency of curettage, the time interval and numbers, as well as the use of steroid therapy before or in lieu of a radical procedure remain unanswered. It is apparent that endocrine imbalance plays an important role in abnormal uterine bleeding. Any discussion in relation to this symptom complex must necessarily include factors that involve the glands of internal secretion. However an elaborate appraisal of this topic is not pertinent to this study at this time.

Dysfunctional uterine bleeding may be defined as that which occurs without demonstrable organic lesion. Other terms are functional bleeding and metropathia hemorrhagica. The complexity of the problem is such that it is often difficult to determine whether this abnormality should be considered as a distinct entity or a symptom of a yet undertermined disease process.

Profuse, prolonged or irregular uterine bleeding may be the first sign of an associated deficiency in the blood clotting mechanism.[8] Iron deficiency anemia may develop because of excessive blood loss and in turn may be productive of more intense menorrhagia. Other systemic causes may be hypertension, cardiovascular disease and hypo- and hyperparathyroidism.[3] Psychic shock or emotional upset is known to have produced irregular or profuse bleeding.[4] Whenever bleeding occurs in women of the childbearing age, it may be secondary to retained products of conception, abortion, or ectopic pregnancy. Although tumor masses or uterine distortion may not be present, maligancy of the cervix, endometrium, tube, or ovary should be eliminated as causative factors.

Dysfunctional bleeding is not uncommon. In a representative study, 5% of gynecologic hospital admissions fell into that classification.[3] While it may be seen at any age, the highest incidence appears in premenopausal women. Ever since the modern concept of menstruation has been advanced, it has been defined as a regular, bloody, uterine discharge associated with the histologic picture of endometrium in the secretory phase. Abnormal bleeding, on the other hand, is often associated with endometrial growth patterns which show lack of progesterone effect. However, numerous studies have demonstrated that there is no single endometrical pattern nor is there any limit to the varieties or relationship to blood loss, duration, or frequency. The study of the endometrium in patients of all age groups where there is abnormal bleeding, is emphasized. In addition to the discovery of heretofore unsuspected organic conditions, it is essential if hormone therapy is contemplated.

Usually menstrual periods begin at the age of 14 to 15. The physiologic variations are such that the interval may be every 21, 28, or 30 to 35 days. What then is to be considered abnormal? Kistner's classification is logical and understandable:[3]

1. Normal bleeding at less than usual intervals.

   Menses that appear at less than an 18 day interval merit investigation.

2. Normal bleeding at more than the usual intervals.

   When the intervals are more than 45 days, a study is indicated.

3. Prolonged or profuse bleeding at nor-

The author wishes to thank G. D. Searle and Company for the supply of medications used in this study, and for the opportunity to conduct the project. Appreciation is also expressed to Derek Calderwood, MD, for his critical review of the manuscript and his pertinent suggestions.

mal intervals.

This problem is relative since the profuseness and duration of the period varies with the individual. In this group, even a greater effort should be made to uncover organic pathology.

4. Constant or irregular bleeding

This is the most common type, and is usually found in premenopausal women.

The variety of measures used in the treatment of abnormal bleeding emphasized the complexity of the subject. No single method has been found to be entirely satisfactory. Before any curative steps are taken it is essential to obtain a complete history and thorough physical examination. A hemogram and the obvious laboratory procedures are integral parts of the evaluation. The next step is uterine curettage. Its role in the treatment of abnormal bleeding has been established, and cannot be disputed. It is impossible to explain why there is improvement in 70% of patients treated by this simple operative procedure. Apart from the methods employed specifically for the control of blood loss, general measures should be taken to improve the patient's systemic health. What are the roles of hysterectomy or radiotherapy? Repeated curettage or the administration of hormones are not effective in every instance. Many patients repeat the abnormal bleeding after a short period of time. How long must one wait before another curettage, and how many operations should be done before instituting radical treatment? Those decisions are governed by the nature and extent of the bleeding, the age of the patient, and her desire for future childbearing. Irradiation for benign uterine conditions has fallen into disrepute because its action is primarily on the ovary rather than the endometrium; and because of subsequently associated detrimental possibilities.

The discussion of the use of the progesterone—estrogen product for the control of abnormal uterine bleeding has deliberately been left for this point. The characteristic effects of the combination of those hormones have been well documented by voluminous literature, and have been generally accepted[3,5,6,10,11] The use of those medications for such maladies as dysmenorrhea, premenstrual tension, endometriosis, and the control of ovulation are also well accepted. Briefly, their action is such that they quickly produce endometrial changes identical with those that are found when estrogen and progesterone are given over a long period of time. The result is an endometrial picture which resembles pregnancy and the maintenance of endometrium free from break-through bleeding. Their efficacy in the control of dysfunctional bleeding, therefore, would be apparent.

A number of patients on steroid therapy have been reluctant to continue because of annoying side effects such as nausea, breast fullness, leg cramps, and headaches. A low dosage product that eliminated the disagreeable effects was developed in the hope that the useful action of the drug would be retained.

Clinical Study

For the purpose of this study, in order to demonstrate the effectiveness of the new product in the control of abnormal bleeding, and the elimination of side effects, a double blind study was made. The medication supplied by the manufacturer was labeled SC-11800 (*Metrulen* 2 *mg.*); the other product was (*Enovid* 5 *mg.*). They were packaged alike and similar in appearance so that the administrator was not aware of the identity of the drug until after completion of the project. The chemical constituents of each product are well known.

A group of 26 patients was studied. They were divided into Category A (14 patients) and Category B (12 patients), depending upon which drug they received. Patients in both groups had been studied previously so that all detectable causes of uterine bleeding were eliminated. A curettage was done prior to the treatment, and the endometrium was studied. Secretory endometrium was found in 8 patients of each group, while the proliferative type was present in 6 of Category A and 4 of Category B. The youngest patient was 15 years of age and the oldest, 40 years. In Category A there was 2 in the 15 to 19 age group; 3 in the 20-25; 2 in the 26 to 30; 3 in the 31-35; and 4 in the 36-40. In Category B there was 1 each in the 15 to 19, 20 to 25 and 26 to 30. In the ages between 31 to 35 there were 4, and in the 36 to 40 group there were 5. Of the 26 patients studied, 16 were over 30 years of age. Fig. 1. The age range and distribution coincides with the findings of other investigators. [3,5,10] The experiment continued for 6 months; there were no dropouts because of intolerance to the drug. The medication was given in

cyclic fashion. Break-through bleeding appeared in two that received the experimental product. When the code was broken it was found that the patients in Category A received SC-11800 (*Metrulen* 2 *mg.*) and Category B, (*Enovid* 5 *mg.*).

Of the 26 patients studied, 24 could be said to have had a satisfactory result. The 2 who had break-through bleeding (one aged 40, the other 37) were treated more intensively. However, every measure proved to be ineffectual, and eventually they were subjected to total abdominal hysterectomy. Although the study was conducted with a comparatively small number, some valuable data were obtained. It would appear that under given circumstances cyclic hormone therapy is beneficial. The fact that side effects were minimal in both groups might suggest a certain amount of psychic involvement. Constant medical attention

CATEGORY A		CATEGORY B	
AGE-GROUP	NUMBER	AGE-GROUP	NUMBER
15–19	2	15–19	1
20–25	3	20–25	1
26–30	2	26–30	1
31–35	3	31–35	4
36–40	4	36–40	5
TOTAL	14	TOTAL	12

Fig. 1—DYSFUNCTIONAL BLEEDING ACCORDING TO AGE—GROUPS

was undoubtedly a factor in the satisfactory results which could not be credited to the drug alone.

Discussion

There are two prevalent theories that explain the cause of dysfunctional bleeding:

1. That the underlying element is a hormonal disturbance,[2] and
2. That bleeding is the result of the effect of autonomic drugs on the uterine vasculature.[2]

Many of the decisions in regard to conservative or radical treatment depend upon the condition of the endometrium obtained at curettage. The judicious use of the Novak curet often provides valuable information and frequently expedites a general gynecologic evaluation. However, the final decision should not be made until a thorough curettage is performed.

When surgical intervention becomes necessary from persistent or recurrent dysfunctional bleeding, when non-hyperplastic endometrium is found in women of premenopausal years, repeated curettage is the preferred treatment. In this group, cyclic hormone therapy should also be considered. For those in the menopausal classification, hysterectomy is the choice when curettage fails. Randall[9] and Corscaden *et al*[1] have shown that the choncer of endometrial carcenoma are three times greater im those individuals than in women who have had a normal menopause. Persistent or recurrent dysfunctional bleeding where hyperplasia of the endometrium of cystic glandular hyperplasia is found, makes hysterectomy the procedure of choice, for two reasons:

1. Because the disease recurs persistently, and
2. Because of the precancerous potentialities.

Summary

Some of the pertinent facts in regard to the origin and treatment of dysfunctional bleeding have been presented. In addition, the results of a double blind study that involved two steroid preparations in the control of abnormal uterine bleeding, have been recorded. An analysis of all of the factors readily demonstrates the complexity of the problems and accentuates the necessity to treat patients upon an individual basis rather than in accordance with a set of standards.

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PERSONAL AND SOCIAL ADJUSTMENT CHARACTERISTICS OF SOME JUVENILE DIABETICS

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Do diabetic children feel that they have been stigmatized or set apart because of their chronic condition? Numerous investigations have sought answers to whether the diabetic child has difficulties concerning his psychodynamic adjustment.

Several studies[1-6] have revealed that there are particular personality patterns which are generally associated with juvenile diabetics. Other studies [7-11] reported that there are no unusual personality characteristics of the juvenile diabetic. The identification and knowledge of what factors influence the diabetic child's adjustment were not consistent in these research studies; thus, an understanding of the problems has been difficult.

In this study, the California Test of Personality (CTP) was administered to a selective juvenile diabetic population (both male and female summer camp members) to determine if their personal and social adjustment status was significantly different from the test norms. Variables within this population (present age, number of siblings, previous camp attendance and duration of diabetes) were also compared to the test norms in an attempt to define what factors may influence the diabetic's adjustment.

Materials and Methods

The subjects were 32 boys and 26 girls ranging in age from 8 to 14 years with an average age of 11.6 years who were attending the two week 1965 Maryland summer camp (Camp Med-Chi) for diabetic children. The purposes of the camp were to provide a camping experience for these children and to promote their diabetic education.

The Elementary Form *AA* of the California Test of Personality was administered (duration: 45 minutes) on Aug. 24, 1965, the second full day the subjects had been at camp. A specific age group (8-14 years) was selected for study because it represented the school grade range for which the norms on the personality test were available. Answers were marked in test booklets and the scoring was objective (yes or no answers). Data on the subjects' intelligence quotients and reading levels were not available for this study. The subjects were arbitrarily grouped according to population variables so as to have nearly equal sample sizes. Three boys omitted answering parts of the test and only the answers given were analyzed. Consequently, there was a variation in the sample number for the boys and for the total population.

The California Test of Personality is divided into two sections: Personal Adjustment and Social Adjustment. Each of these is then subdivided into six components (Table 1) whereby certain important personal and social characteristics are identified. Total Adjustment refers to life adjustment as a balance between personal and social adjustment. Precise definitions of these test components can be obtained in *CTP* Manual.[13] In general, the *CTP* provides normative data which

TABLE 1

Areas of adjustment in the California Test of Personality

Components of personal adjustment

- S-rel.—Self-reliance
- Per. Wth.—Sense of Personal Worth
- Per. Fdm.—Sense of Personal Freedom
- Belg.—Feeling of Belonging
- Wd. Td. (Fdm. fr.)—Freedom from Withdrawing Tendencies
- Ne. S. (Fdm. fr.)—Freedom from Nervous Symptoms
- Total Per. Adj.—Total Personal Adjustment (All per. adj. components inclusive)

Components of social adjustment

- Soc. Sn.—Social Standards
- Soc. Sk.—Social Skills
- A-s. Td. (Fdm. fr.)—Freedom from Anti-social Tendencies
- Fm. Rel.—Family Relations
- Sc. Rel.—School Relations
- Cm. Rel.—Community Relations
- Total Soc. Adj.—Total Social Adjustment (All soc. adj. components inclusive)
- Total Adj.—Total Adjustment: Combination of both personal and social adjustment

TABLE 2

Median percentile ranks as determined from the California Test of Personality for all variables of all test components

			BOYS								
			Age Years		Siblings			Attended Camp Before	Not At Camp Before	Duration of Diabetes	
Test Components*	Total Population	All Boys	<11.6	>11.6	0-1	2	3-7			<3 yrs	= >3 yrs
S-rel.	53.6	55.1	54.2	56.3	63.3	49.0	59.0	53.6	59.4	55.7	54.6
Per. Wth.	60.1	56.3	60.4	52.4	53.0	56.8	67.3	62.2	56.9	59.0	55.1
Per. Fdm.	43.9	40.4	35.5	46.6	40.6	50.2	33.2	41.1	41.5	41.2	39.6
Belg.	44.2	42.9	34.4	51.2	50.0	38.5	44.6	46.7	42.8	42.1	43.6
Wd. Td. Fdm. fr.	48.2	43.2	39.4	48.1	44.5	44.5	43.7	47.1	42.6	41.8	45.7
Ne. S. Fdm. fr.	46.1	48.3	37.5	59.4	53.0	48.1	46.2	48.8	49.5	43.0	52.0
Total Per. Adj.	42.9	42.0	37.2	48.1	44.5	43.0	42.6	46.7	41.2	38.7	44.8
Soc. Sn.	47.3	43.6	42.7	44.6	47.1	41.8	47.5	48.8	43.2	44.8	42.5
Soc. Sk.	54.0	53.1	50.0	56.8	48.0	53.9	57.1	49.6	57.6	57.5	49.5
A-s. Td. Fdm. fr.	30.3	25.8	24.3	27.7	29.2	21.1	32.7	37.8	20.1	17.3	33.3
Fm. Rel.	38.6	36.5	32.9	41.1	39.3	45.6	29.7	36.9	40.1	38.9	34.4
Sc. Rel.	40.2	38.0	41.2	34.2	38.5	39.5	46.1	44.6	37.7	38.4	37.7
Cm. Rel.	38.7	33.4	30.6	36.8	31.5	44.3	30.4	30.5	39.2	38.1	29.5
Total Soc. Adj.	36.0	32.5	30.6	35.1	35.0	33.0	35.5	39.2	31.2	28.7	35.9
Total Adj.	40.4	37.9	34.4	42.4	40.5	38.5	40.2	43.8	37.1	4.13	41.2

		GIRLS							
		Age Years		Siblings		Attended Camp Before	Not At Camp Before	Duration of Diabetes	
Test Components	All Girls	<11.6	>11.6	0-2	3-6			<3 yrs	= >3 yrs
S-rel.	51.8	45.5	56.3	56.6	48.3	56.1	48.2	53.9	49.2
Per. Wth.	63.9	62.2	65.2	68.3	60.3	68.3	59.6	67.3	60.0
Per. Fdm.	48.3	46.4	49.8	53.2	43.8	54.4	41.4	53.6	42.2
Belg.	46.0	45.4	46.3	47.3	45.8	54.3	36.8	48.2	43.3
Wd. Td. Fdm. fr.	54.2	52.3	55.7	55.0	52.9	63.2	42.3	59.3	49.2
Ne. S. Fdm. fr.	43.5	40.4	45.7	52.7	36.3	56.1	30.5	41.8	44.7
Total Per. Adj.	44.0	40.9	46.3	48.8	40.0	52.1	35.0	46.8	40.8
Soc. Sn.	51.9	44.5	57.3	53.1	54.2	54.3	51.8	45.7	58.3
Soc. Sk.	55.0	58.6	52.3	52.7	56.2	51.8	55.1	56.4	55.0
A-s. Td. Fdm. fr.	35.8	27.3	42.1	45.8	27.5	46.4	27.7	35.8	36.7
Fm. Rel.	41.2	45.2	38.2	42.1	40.2	43.4	37.5	43.0	39.0
Sc. Rel.	42.7	49.1	38.0	40.0	44.2	44.3	40.9	49.3	35.0
Cm. Rel.	45.0	50.0	41.3	43.1	47.5	44.3	44.5	49.3	40.0
Total Soc. Adj.	40.4	42.7	38.7	41.5	40.0	42.1	38.2	43.6	36.7
Total Adj.	43.5	42.7	44.0	46.9	40.8	49.3	37.3	46.4	40.0

* See Table 1 for meanings of the abbreviations

may represent a gauge for appraising the existence and the seriousness of adjustment problems. The test results are dependent upon the willingness of the subjects to introspect. With a test of this type, some children may be prone to misinterpret the questions because of their limitations in vocabulary and concept development and their inexperience in being objective about non-objective events.

The norms of the *CTP* are expressed in terms of percentile ranks (the percent of scores in a distribution equal to or lower than the score corresponding to the given rank) with the median for the test at the 50th percentile. In this study, the raw scores for each individual were converted, using the *CTP* tables, into percentile ranks for each test component and for the three test totals. Frequency distributions for each test component and for the adjustment totals were obtained for the number of subjects in the population and in each of its variables. The median percentile ranks (MPR) were calculated for the population and its variables and for all test components by summing the percentile ranks for all subjects and then dividing by the number of subjects (Table 2).

The statisticial treatment of the data employed the non-parametric Kolmogrov-Smirnov One-Sample Two-Tailed Test.[14] This is a goodness of fit test which was used since it is applicable for small samples. A summary of the significant levels of deviation from the norms of the *CTP* will be found in (Table 3).

Results and Discussion

Several characteristics appeared to emerge from the results of this study, although, the group in this study is not representative of the total juvenile diabetic population. The Personal Adjustment for this population had few areas which were significantly different when compared to the test norms. The total of the ($P<.05$/MPR of 63) and the girls who had attended camp before ($P<.05$/MPR of 68) were significantly better than the *CTP* norms in their Sense of Personal Worth. The total camp population did not differ significantly from the norms of any of ther personal adjustment components except Sense of Personal Worth ($P<.05$/MPR of 60). All the population variables for Sense of Personal Worth had MPR's above the 50th percentile for both boys and girls. This population, but particularly the girls, seemed to have a positive attitude of acceptance toward their situation and an adequate self-concept. It may be possible that the pattern for Sense of Personal Worth was actually some form of compensation for de-emphasizing the diabetic condition, but this seems unlikely.

The younger boys showed some negative deviations on the component of Sense of Personal Freedom ($P<.05$/MPR of 35) and Feelings of Belonging ($P<.05$/MPR of 34). They appeared to feel restricted and to be less personally involved with people (inadequate feelings of belonging) even though it is indicated that they have a high Sense of Personal Worth (MPR of 60). A possible explanation for these deviations might be that the younger boys have had limited chances to make decisions and were perhaps subjected to over-solicitous parents as suggested by Fischer and Dolger[2]. It was also stated by Knowles *et al* [15] that the diabetic child expressed hostility because of the need for self-assertion.

The social adjustment of this population showed negative statistical differences on many test components. The deviations within the population variables exhibited a trend which may indicate reasons for the population's poor social adjustment. All the boys ($P<.01$/MPR of 25), the boys who had not been to camp before $P<.01$/MPR of 20, and the boys who had diabetes less than three years ($P<.01$/MPR of 17) showed poor adjustment on the test component of Freedom from Anti-social Tendencies. Of the 15 boys who had had diabetes less than three years, nine were younger than 11.6 years and 13 had not been to camp before. All three variables showed a greater number of test components which varied significantly from the test norms. Because of the interrelationship of these three variables, none can be shown to be more significant for these boys.

No similar relationship between test variables was observed for the girls. Only the younger girls ($P<.01$/MPR of 27) and those who had three to six schlings ($P<.05$/MPR of 27) had significant difficulty in Freedom from Anti-social Tendencies. The denial or non-acceptance of diabetes might influence these children's anti-social tendencies since they may be unwilling to admit freely to others the presence of their chronic condition. Knowles *et al*[15] pointed out that at camp these youngsters may successfully experi-

TABLE 3

SUMMARY of the significant levels* of deviation† from the norms of the CALIFORNIA TEST of PERSONALITY due to population variables and test components

Test Components‡	Total Population	All Boys	Age Years <11.6	Age Years >11.6	Siblings 0–1	Siblings 2	Siblings 3–7	Attended Camp Before	Not at Camp Before	Duration of Diabetes <3 yrs	Duration of Diabetes =>3 yrs
	BOYS										
S-rel.											
Per. Wth.	.05 (211)/(178)										
Per. Fdm.			.05 (329)/(309)								
Belg.			.05 (318)/(309)								
Wd. Td. Fdm. fr.											
Ne. S. Fdm. fr.											
Total Per. Adj.											
Soc. Sn.											
Soc. Sk.											
A-s. Td. Fdm. fr.	.01 (315)/(214)	.01 (382)/(290)	.01 (429)/(371)	.01 (494)/(418)		.05 (449)/(410)			.01 (462)/(371)	.01 (518)/(404)	
Fm. Rel.	.05 (211)/(178)		.05 (329)/(309)								
Sc. Rel.	.01 (278)/(216)	.05 (289)/(240)							.01 (392)/(381)		
Cm. Rel.	.01 (278)/(216)	.01 (319)/(290)	.05 (329)/(318)	.05 (350)/(349)							.05 (350)/(318)
Total Soc. Adj.	.01 (280)/(214)	.05 (257)/(240)								.05 (351)/(338)	
Total Adj.	.05 (208)/(178)		.05 (329)/(309)								
N	57–58	31–32	17–18	14	10	9–10	9–10	12	17–18	14–15	17

Test Components	All Girls	Age Years <11.6	Age Years >11.6	Siblings 0–2	Siblings 3–6	Attended Camp Before	Not at Camp Before	Duration of Diabetes <3 yrs	Duration of Diabetes =>3 yrs
	GIRLS								
S-rel.									
Per. Wth.	.05 (272)/(270)					.05 (349)/(349)			
Per. Fdm.									
Belg.									
Wd. Td. Fdm. fr.									
Ne. S. Fdm. fr.									
Total Per. Adj.									
Soc. Sn.									
Soc. Sk.									
A-s. Td. Fdm. fr.		.01 (478)/(468)			.05 (418)/(375)				
Fm. Rel.	.05 (274)/(270)							.05 (350)/(349)	
Sc. Rel.	.05 (312)/(270)								
Cm. Rel.									
Total Soc. Adj.	.05 (312)/(270)					.05 (350)/(349)			
Total Adj.	.05 (274)/(270)								.01 (450)/(450)
N	26	11	15	13	12	14	11	14	12

* Determined by the Kolmogorov-Smirnov one-sample two-tailed test[14]

† The values given are the level of confidence and (maximum deviation)/(critical value)

‡ See Table 1 for meanings of the abbreviations

ence achievement that they previously thought impossible (making friends, self-responsibility such as administering insulin injections and being cooperative). In their relationship with their siblings, these youngsters may not understand why their brothers and sisters are not diabetic. Etzwiler and Sines[16] concluded in their investigation that diabetic children have an inadequate understanding and a lack of insightfulness into the fundamental concepts of their diabetic condition.

The total population ($P<.05$/MPR of 38), all the girls ($P<.05$/MPR of 41) and two other population variables deviated significantly in Family Relations. These children's feelings of insecurity or inferiority in their home relations may be due to their family's attitudes of guilt and lack of the acceptance of their condition. Knowles *et al* [15] hypothesized that the possible hereditary factor involved in this condition may cause the parents to have guilt attitudes. However, Etzwiler and Sines[16] showed that parents, in general, had good contact with reality and an absence of neurotic manifestations. It would seem that more experimental study is needed in this area of the diabetic child's family relations.

In Total Adjustment, the total population deviated significantly ($P<.05$/MPR of 40) from the norms. In Total Social Adjustment, significant deviations occurred for the boys who had diabetes less than three years ($P<.05$/MPR of 28) and for the girls who had attended camp before ($P<.05$/MPR of 42). The poorer social adjustment of these girls may be due to chance clumping of the data (all percentile ranks between 20 and 60%). Because of the relatively high MPR's, one may question whether this statistical result is indicative of the true nature of the population variable. This may also be true of some other variables within the test. By chance alone, one would expect some erroneous results. The total population and particularly the boys in several of the variables appeared to have difficulty in adjusting to school and community life. The total of the girls ($P<.05$/MPR of 42) also showed significantly low adjustment in school. There may be an element of anxiety[15] (a feeling of being alone with the disease) present which caused the children to have difficulties adjusting to their school life.

Summary

The California Test of Personality was administered to a selective juvenile diabetic population to determine if their personal and social adjustment status was significantly different from the test norms. Variables within this population were also compared to the test norms in an attempt to define what factors in a diabetic's life may have influenced his adjustment. This population was found to be better adjusted personally than socially. A tendency for a high sense of personal worth was found for this population, particularly for all the girls and those girls who had previously attended summer camp. The girls seemed to be better adjusted socially than the boys in this study. The younger boys had greater difficulty in social adjustment.

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WHAT THE SOCIAL SECURITY DISABILITY PROGRAM MEANS TO YOU AND YOUR PATIENTS

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In 1965, social security coverage was extended to physicians in private practice. Its disability protection can be a valuable supplement to your present disability coverage.

In the social security disability program, a person under 65 who is too physically or mentally disabled to work may receive up to $152 in monthly benefits. If he has dependents, family benefits can go as high as $339 a month.

Benefits can now be paid to a person whose disability has lasted or is expected to last for 12 months or longer, or to result in death. (Formerly, a person was eligible only if his impairment was expected to continue for a long and indefinite time, or to result in death.) This liberalized provision benefits a large number of persons disabled by non-permanent impairments resulting from accident or illness.

Already, in Maryland, some 14,000 disabled persons and 3,000 dependents are receiving about $1,400,460 a month in social security disability benefits. Nationwide, over a million disabled persons—plus about a million dependents—are getting payments of about $1.75 billion a year from the program.

You may have patients who are eligible for benefits but are unaware of the provisions of the law. You can perform a valuable service by refering them to a social security office for further information. You can also help speed the decision on your patient's claim by promptly responding to his request that you report the medical data from your records needed to evaluate his disability.

To give you a better understanding of how the program relates to your practice, here are answers to the questions physicians most frequently ask about the social security disability program.

ADVISING PATIENTS

Where do I send a patient to inquire about disability benefits?

Refer him to his social security office. If he cannot get there because he is in a hospital or is unable to leave home, the office will send a representative to visit him.

What do you mean by "disabled"?

A "disabled" person is one who has a physical or mental impairment that prevents him from doing not only his usual work, but any substantial work in keeping with his age, education, and experience.

Is the impairment the only factor in determining disability?

Not always. In most cases, a person who is found disabled has an impairment so severe that his condition alone prevents work activity. But it is possible for a person to be considered disabled because of a combination of medical and vocational considerations. This occurs when the medical condition prevents him from doing his usual work and—considering his age, education, and previous

work experience—he cannot be expected to do any other type of work.

Are benefits paid only in cases of permanent disability?

No. Benefits are paid if the disability has lasted or is expected to last at least 12 months or to result in death. This covers non-permanent impairments resulting from accident or illness as well as chronic conditions.

How soon can benefits start?

Benefits begin after a waiting period of 6 full calendar months following the onset of disability. Therefore, the first payment is for the 7th month after the month in which a person became disabled.

What about a person who did not apply for benefits while he was still disabled? Can he receive any back payments now that he is recovered?

Yes. Even a person who has returned to work may be eligible for some benefits if severe disability prevented him from working for at least 12 months. However, the longer the delay between his recovery and his application for benefits, the fewer months of back payments he can receive. If more than 14 months elapse after he recovers and before he applies, no benefits are payable.

A cardiac patient who gets angina on slight exertion tells me you turned down his claim.

Probably for a non-disability reason, such as his not having worked long enough in jobs covered by social security to meet the disability earnings requirement. To acquire disability protection, a worker must generally have social security work credits for at least 5 of the 10 years preceding the onset of his disability. (Note: Persons disabled by blindness before age 31 may need less than 5 years. Inquire at a social security office for further information.)

What are the most common impairments among workers who are found disabled?

The most frequent causes of disability have been: arteriosclerotic heart disease (including coronary disease), emphysema, schizophrenic disorders, hypertensive heart disease, pulmonary tuberculosis, osteoarthritis and rheumatoid arthritis. These conditions may help you identify patients likely to be qualified for benefits. But don't feel that they limit you in any way. Send any patient you think qualified to his nearest social security office.

Someone disabled from birth-or never been able to work.

Under the "childhood disability" provisions, a person continuously disabled since before age 18 can receive disability benefits starting at age 18 or later. He need not have a work record of his own. Benefits can be based on the earnings record of either parent. Payments begin when a parent covered under social security dies or becomes entitled to disability or retirement benefits. Benefits can continue as long as the son or daughter remains disabled.

The most common causes of disability in this program are mental retardation, epilepsy, cerebral palsy, congenital defects, and late effects of acute poliomyelitis, congenital syphilis and acute encephalitis.

THE DISABILITY DECISION

Who determines whether or not a person is disabled?

Disability decisions are made by a State agency evaluation team consisting of a physician and a counselor skilled in vocational evaluation. In Maryland the agency is in the Division of Vocational Rehabilitation and is designated as the Disability Determination Program.

Typically, the evaluating physician is a private practitioner serving the agency on a part-time basis. He reviews the medical, hospital and laboratory reports and, in conjunction with the vocational evaluator, decides whether the applicant's impairment is disabling under the law.

Does the State agency physician also examine the applicant?

No. He depends entirely on the evidence reported by you and others who have examined or treated the applicant.

Can a person appeal the denial of his claim?

Yes. He is entitled to have his claim reconsidered, submitting any new evidence that may be available. If his claim is again disallowed, he can have it ruled on by a hearing examiner located near his home. As a further appeal, the claimant can request that the decision in his case be reviewed in Washington, DC, by the Appeals Council of the Bureau of Hearings and Appeals. Then if he is still dissatisfied, he can file suit in his local US District Court to have the decision reviewed.

REPORTING MEDICAL EVIDENCE

What kind of medical report on my patient should I submit?

Submit a standard narrative report, such as you would send any colleague to give a complete medical picture of the patient. This should include the history, and physical and laboratory findings—as much objective data from the patient's chart as possible.

Who pays for my report?

Your patient is legally responsible for providing initial medical evidence in support of his claim. Therefore, he is responsible for any fee you would charge for preparing your report.

Is the initial report from the treating physician all the medical information the State agency needs to decide a case?

In many cases, yes. Frequently, reports from other treatment sources such as hospitals and clinics are also used. If the evaluating physician requires certain data that was not reported, he may call or write you to find out if you have the needed information in your records. When necessary, medical examinations by qualified independent sources are arranged by the State agency.

Who are these independent sources?

Generally, other physicians in private practice. Any qualified physician may ask the State agency to place his name on its consultant roster to perform examinations.

How are the consultants' fees set?

The fees are based on a schedule which the agency has worked out with the assistance of its representative medical advisory committee.

MOTIVATING REHABILITATION

What is done for applicants who need rehabilitation help?

Every applicant filing for benefits is considered for possible services by the Maryland Division of Vocational Rehabilitation. Such services include counseling, teaching of new employment skills, training in the use of prostheses, and job placement. These services are generally financed from State-Federal appropriations. Additional resources are now provided through social security funds to pay the costs of rehabilitating certain disability beneficiaries.

Do benefits stop when a beneficiary who has not recovered goes back to work?

Generally, not right away. A person who tries to work DESPITE HIS MEDICAL DISABILITY is usually given a "trial work period" of 12 months of continued benefits.

This is intended to reassure a person who might hesitate to go back to work for fear of losing his benefits before he knows whether he can hold down a steady job. Benefits are stopped at the end of the trial work period only if the beneficiary has shown that he has regained his ability to do substantial gainful work.

What happens when a beneficiary recovers medically?

His monthly benefit checks are continued for the month of recovery and 2 additional months. This is to help him adjust financially to being self-sufficient. Then, since he is no longer disabled, his benefits stop.

To be sure that beneficiaries continue to qualify for benefits, there are periodic reviews of all cases in which recovery is thought possible.

Does a person who has recovered or returned to work get special consideration if he becomes disabled again?

Yes. If he again becomes disabled within 5 years, the 6-month waiting period normally required before benefits begin is waived. He can immediately become reentitled to benefits, as long as he is still insured for disability purposes.

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Family Planning and the Role of the Maryland State Department of Health

J. King B. E. Seegar, Jr., MD
Chief, Maternity Section
Division of Maternal and Child Health

The ramifications of family planning and birth control are so diverse that today an organized program would seem to be a major factor in solving some of the most pressing problems in the world and our community. I should like to discuss some of the aspects, pointing out specifically the work in family planning accomplished to date by the Maryland State Department of Health, and the type of program we should like to implement for the future.

To me the most urgent and frightening problem today is that of the world population explosion. Prior to the advent of modern science, population control was no problem; the appalling death rate from war, pestilence, and famine controlled population growth. Today the issue is one of population control now by effective contraception or later by starvation.

Dr. Robert C. Cook[1] has pointed out that at the beginning of the Christian era the world population was approximately one quarter of a billion, and required 16 centuries to double to one half a billion. By 1850, the world population had doubled again to one billion, and since then has more than tripled itself, now standing at 3.4 billion. At the present rate of growth of 2% a year, world population doubles in 35 years, which would mean a world population of 24 billion in 100 years. It is true that the most rapid and dangerous growth is in the underdeveloped countries of Asia, Africa, and South America. Yet, how long could the nations of the western world survive in plenty, with famine sweeping three fourths of the globe? Actually here in the United States, though our birth rate is declining, we still are doubling our population every 44 years.[2–3]

At present, the annual food supply of the world is insufficient and it is estimated that hunger is endemic for more than half the human race. Congressman Harold Cooley at a hearing of the House Agriculture Committee in 1966 reported that 12,000 people were dying daily from starvation, or more than 4,000,000 a year.[4]

There are those who argue that we should concentrate our efforts on the development of major new food technologies rather than directing them toward population control. Mobilizing world forces along these lines perhaps could solve the world food problem temporarily. However, in the population explosion we are dealing with a mathematical term known as an "exponential" which is a function rapidly approaching infinity, and soon becoming uncontrollable. Consequently, without a control on population growth, food supplies ultimately will fail before the realities of the exponential.[4]

In addition to this, overpopulation disturbs the balance of nature, creating problems of air, water, and soil pollution. These I shall not discuss, but mention here merely to point out the gravity and scope of our situation.

Next in importance we should consider the medical implications of family planning for both mother and child. Here unfortunately, there has been far too much said about the possible ill effects of some of the contraceptives. People are being unduly frightened by various articles concerning the possible dangers of thrombophlebitis associated with the use of the contraceptive pills. Yet rarely, if ever, in these writings have I seen

the counter statement that, if this complication results, the incidence probably is no greater than that seen in normal pregnancies. Consequently, it would seem there is nothing to loose by taking pills to prevent an unwanted pregnancy. In addition to this, by preventing a pregnancy the individual in many cases is avoiding a number of serious complications of pregnancy, many of which may be fatal. This would seem to weigh the scales in favor of the contraceptive pills.

Interesting medical evidence supporting family planning is found in a study made in India by Gordon, Singh, and Wyon.[5] They found that the neonatal mortality showed a definite decrease when deliveries were spaced 24 or more months apart, and that this also was reflected in the infant mortality. They showed further that with the exception of the high infant mortality rates associated with primiparity, there seemed to be a rise in infant mortality as parity increased.

Furthermore, limitation of the family is medically desirable. It is a well established fact that with multiparity there is an increase in obstetrical complications, creating a hazard to both mother and baby. Recently Dr. Meier[6–7] in a study of multiparous women who were welfare recipients in an urban area found that one fifth of the women had serious health hazards before their fourth pregnancy. In a follow up of these patients it was learned that after the fourth pregnancy an additional two fifths developed serious health problems.

These generalities certainly emphasize the drastic need for population control. One may say this is true for the world, but how does it apply to us in Maryland? Recently there have been several articles in the Sunpapers[8–9] indicating that on a percentage basis we are one of the fastest growing states in the Union. It was pointed out that in Maryland there are 14 new cities in various stages of planning and construction. It is true that a fair part of this growth is due to imigration. Yet, in the year ending July 1, 1966, there was an estimated increase of 80,740 people in Maryland bringing the total to 3,632,140. This is a 2.3% increase which is an interesting comparison with a 2% increase in the world population, and a 1.2% increase in the population of the United States. To illustrate the need for Health Department family planning clinics here, it was estimated that in 1966 there were 78,570 medically indigent Maryland women in need of this service. This figure was arrived at through the *Polgar Formula*[10] which estimates for a community, at any given time, the approximate number of medically dependent women of childbearing age who are fertile and not pregnant or seeking a pregnancy.

Actually, though there is still much to be done to meet this need, the Health Department is proud of its progress. In 1962, there were but four subdivisions offering family planning services. Now in the spring of 1967 this service is available through the Health Department in all 24 political subdivisions, one third of them having a number of clinic locations. Every subdivision offers a choice of contraceptive methods, and in all but two the intrauterine device is available. We are especially proud of the *Guidelines for Family Planning Clinics* which we developed, and which the National Planned Parenthood Association has asked our permission to distribute throughout the country.

The field of public relations and education has not been neglected. We have spoken before several county medical societies on the subject of our program and have met individually with a number of physicians throughout the State regarding our aims. Efforts have been made to stimulate interest in educational in-service programs for public health nurses at The Johns Hopkins and the Planned Parenthood Association.

At the moment the Public Health Nurse is the backbone of our program. She circularizes family planning information throughout the counties on home visits, and in Health Department clinics, especially pediatric and obstetrical. It is she to whom the patients most frequently confide their misgivings, and who through her understanding persuades the patient to attend the clinic.

Favorable comments of our program and clinics have appeared in Baltimore and county papers. Also, the *Bulletin of the Maryland State Department of Health* devoted the November-December 1966 issue to Family Planning in Maryland. It generated considerable interest, and requests for copies were received from many health, welfare, and social agencies.

Finally, through the cooperation of MEDIC (the telephone network which brings medical educational programs to physicians throughout the State) there have been several educational pro-

grams conducted on the subject. In April, 1967 several talks on Population Dynamics and Population Control were heard simultaneously in 32 locations in the State, and to which were invited Social Service workers from the State and local welfare departments.

Eventually it is essential to devise some method of evaluating our program. This is especially difficult, since there is no single index by which we can gauge our progress.

To this end we have developed several charts and graphs which we hope will be of comparative value in future years. Our first table (Table I) showing the total number of Maryland family planning patients registered with the Health Department, Planned Parenthood Association of Maryland and Planned Parenthood of Metropolitan Washington, DC, Inc. for the year ended June, 1966. These figures are compared with the total number of patients in need of this service as indicated by the *Polgar Formula*. From this it may be seen that together we are caring for 13,595 indigent women leaving 64,975 yet to be reached. A more recent report from the counties and Baltimore City would indicate that as of December 31, 1966 we were reaching 2,739 more women or a total of 16,334 leaving 62,236 still without this service. Not all of these women may desire the service because of personal preferences or other factors. A number are certainly receiving care through private physicians or hospital clinics.

At present nearly all of our family planning patients in the counties are referrals from the maternity clinics. I believe it is interesting to note that the number of new family planning patients in the counties for the year is equal to 75.8% of clinic patients delivered. The total number of family planning patients both carried over and new, equaled 129% of clinic patients delivered. These comparisons give some indication as to the popularity and acceptance of our program, and indicate that the obstetrical clinics are adequately recognizing their responsibility for referrals and accepting family planning as an integral part of obstetrical care.

The first chart (Figure I) shows a comparative study of the patients receiving family planning services in each county health department as a per cent of the *Polgar Formula* estimated need. In succeeding years the number of patients receiving this service in each county should increase thus raising their percentage closer to the ideal 100%.

Our second chart (Figure II) was drawn up with the thought that the target number of new family planning patients in each county should be 10% of the *Polgar Formula* estimate. Here it is seen that there is a wide variation between the counties. Two had not opened their clinics by July, 1966 and a number of others were just getting underway. It is hoped that for the 1967 fiscal year the graph will not show such a wide variation.

The latest statistics released by the Maryland State Department of Health show that there were 2500 fewer babies delivered in 1966 than in 1965 and that the birth rate for the State fell from 20.9 per 1000 population in 1965 to 19.7 in 1966. Bettie Rogerson, MD, Acting Chief of the Division of Biostatistics of the Maryland State Health Department, states that the decline in the birth rate in Maryland has accelerated in the past two years. She points out that between 1957 and 1964 the birth rate for Maryland showed an over-all decline

Table I
ESTIMATED NUMBER OF MEDICALLY INDIGENT WOMEN IN NEED OF FAMILY PLANNING SERVICES, THREE MARYLAND AREAS, FISCAL YEAR 1966

Area of Residence	Total Estimated Need From Polgar Formula*	Patients Registered with Health Departments for Family Planning Services	Patients Registered with Planned Parenthood	Patients Still to Reach
State of Md.	78570	6595	7000	64975
Baltimore City	25690	3500	5500	16690
Total Counties	50880	3095	1500	48285

*** The Polgar Formula determines for a community, at any given time, the approximate number of medically dependent women of childbearing age who are fertile and who are not pregnant or seeking pregnancy.**

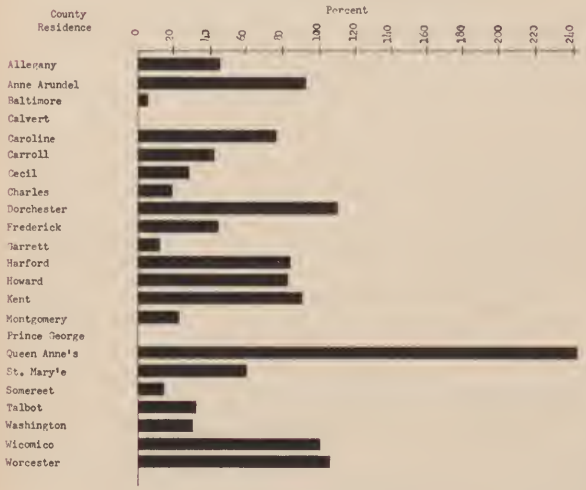
FIGURE I



Total Patients Registered for family planning services with the County Health Departments as a Percent of the Estimated Number of Medically Indigent Women in Need of Family Planning Services, Each County of Maryland, Fiscal Year 1966.

FIGURE II

New Patients registered for family planning services with County Health Departments as percent of Target* Population, each county of Maryland, 1966 Fiscal Year.



*Target Population set as 10% of total number of medically indigent women of childbearing age who are fertile and who are not pregnant or seeking pregnancy as estimated by the Polgar Formula.

of 13 per cent. Between 1964 and 1966 she states the rate fell by an additional 14%. Family Planning may not be solely responsible for this trend, but it most certainly plays a part and is encouraging to us.

However proud we are of our accomplishment, we are well aware that still there is much to be done. Though good clinics may form an excellent foundation, they alone do not constitute a program. At this point we are greatly in need of personnel. In a few counties we have been able to offer direct services which have proven most successful. On the basis of this experience we should like eventually to engage four physicians as OB and GYN Regional Directors. Each would be assigned a quarter of the State where he would direct that part of the Maternal and Family Planning program. Here, however, it would appear most sensible to expand slowly, one area at a time. There is also the need for a physician skilled in genetic counselling. Next we believe there are certain problems that can best be solved by the employment of aides. These aides would work in the communities where they live and would be given a course of training at Planned Parenthood Association in Baltimore, where they would learn to set up clinics, instruct patients, keep records and assist the physician in examinations. It is also hoped that they may make follow-up visits to the home to be sure that the patient is carrying out instructions correctly. Many patients miss clinic appointments because of lack of transportation and the need for baby sitters. Arrangements for these could be one of the aides duties. They could also develop facilities for delivering pills to patients unable to pick them up at the clinics. We would like to begin with 10 aides. To supervise these aides the services of one maternal and child health nursing advisor would be necessary. Prominent on our essential list is at least one health educator. It would be his duty to disseminate health and family planning information through all available channels. This would include utilizing the local press, radio or television programs; organizing small groups in private homes where family planning can be discussed; and generally availing themselves of any other opportunities for public health endeavors. Finally a social worker and two stenographers would round out our personnel requirements. We feel that this investment would be well worthwhile and in the long run would result in an economic savings for the community. In a study of family planning in North Carolina's Mecklenburg County the statement was made, "We are spending a dollar to save $25.00."

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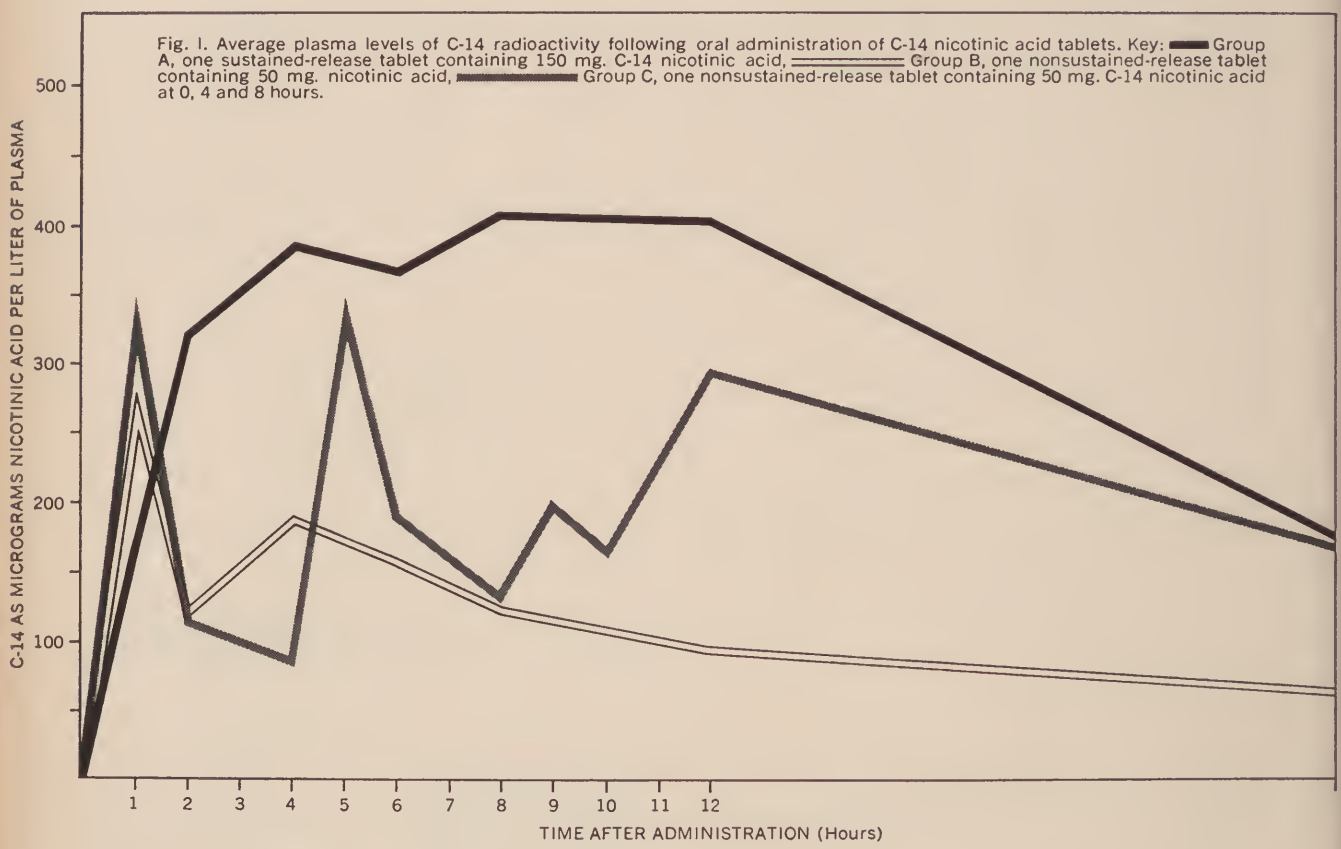
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Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▬▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.





(fewer absent doses by absent-minded patients)

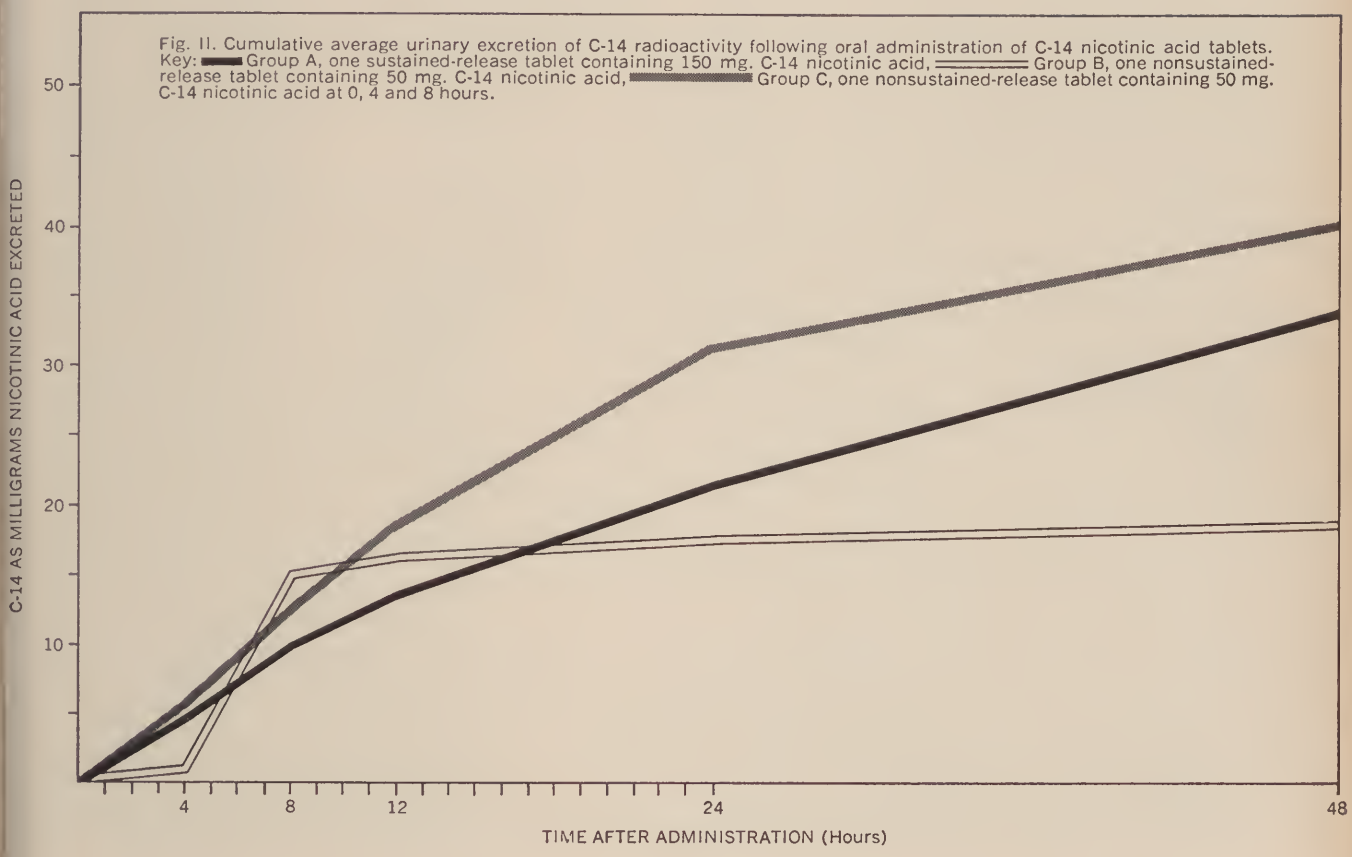
Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

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References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.

Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.

Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.

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Scoliosis

T. H. MORGAN, MD, FRCS, (Eng.)
Division of Orthopaedic Surgery
University of Maryland

Scoliosis is defined as a lateral curvature of the spine: this may vary from a slight curve to a severe deformity, which may be crippling and even life endangering.

Attempts to classify scoliosis on a pathological basis have led to complex classifications which tend to confuse rather than clarify. The one below, whilst incomplete, covers the great majority of scolioses, and as such, is adequate for the understanding of this condition—the purpose of this paper.

CLASSIFICATION

1. Non-progressive Scoliosis
2. Progressive Scoliosis
   - Congenital
   - Acquired
   - Idiopathic
   - Paralytic
   - Neurofibromatosis and other Neurological conditions

NON-PROGRESSIVE SCOLIOSIS

In non-progressive scoliosis, the spine is structurally normal, the curves resulting from defects outside the spinal vertebrae. There are three common types:

- Postural
- Secondary
- Reflex

Postural scoliosis occurs mainly in adolescents towards the end of the growth period. It is usually a mild lateral curvature due in many cases to lack of tone in the back and trunk muscles. The deformity is fully correctable, disappearing when the spine is flexed by the patient touching his toes in the erect position. Structural changes in the vertebrae, such as wedging and rotation do not occur, and there is no evidence to suggest that a postural curve becomes a progressive scoliosis.

Secondary scoliosis is, in a sense, also postural, for example, a patient with obliquity of the pelvis due to a short leg, will produce a lateral curvature of the spine in an attempt to correct his posture; when the leg length is equalized, but curvature will disappear. In some patients, however, where there has been a marked disparity in the leg length throughout a large part of the growth period, secondary structural changes may occur in the spine, due to abnormal pressures on the vertebral epiphyses, and in these cases the curves are not always fully correctable.

Reflex scoliosis is the name given to the lumbar curve frequently associated with unilateral erector spinae spasm, e.g. in an acute prolapsed intervertebral disc lesion. When the spasm passes off, the curvature disappears.

PROGRESSIVE SCOLIOSIS

CONGENITAL.

In this type of scoliosis, the curves are secondary to congenital malformations of the bony structure of the spine. The commonest abnormality being the hemivertebra which may be single or more commonly multiple, in addition there may be

associated abnormalities such as spina bifida, congenital fusion or absence of ribs, and cardiac defects.

The degree of angulation of a congenital curve will depend on the mechanical effect of the abnormality. Thus two hemivertebrae on one side of the spine may produce a marked curve, but if they are situated on each side of the spine, their individual effect is neutralized.

The commonest site for congential abnormalities is the cervico-dorsal spine, and lumbo-sacral junction. These curves are progressive, but usually comparatively slowly, the ultimate deformity depending to a large extent of the severity of the curve at birth.

ACQUIRED

Acquired scoliosis is essentially a disease associated with growth, starting at any time between infancy and the end of the growth period. In the great majority of patients, the curves progress during this period, and stop only when growth ceases; the resulting deformity remains for the rest of life.

IDIOPATHIC SCOLIOSIS

This is the most common type of acquired scoliosis, and is so named because its etiology is unknown. It appears to be a definite disease; being particularly apparent from analysis of variations in curve pattern occurring in scoliosis of different etiologies. In idiopathic scoliosis there are four such patterns, named according to the area of the spine affected.

Curve Patterns

1. Dorsal where the curve is restricted the thoracic spine.
2. Dorso-lumbar where the curve extends from the dorsal spine into the lumbar spine.
3. Lumbar where the curve is restricted to the lumbar spine.
4. Combined curve pattern where there is both a dorsal curve and a lumbar curve, with apices in opposite directions. (The *"S"* shaped curve)

The curve patterns are of significance because their individual symptomatology is varied, and they tend to occur at different ages. For this reason, it is convenient to further subdivide idiopathic scoliosis into three groups according to age of onset of the curvature:

1. Infantile group, onset between birth and 2 years.
2. Juvenile group, onset between 2 and 10 years.
3. Adolescent group, onset after age of 10 years.

INFANTILE IDIOPATHIC SCOLIOSIS

This type of scoliosis, whilst relatively uncommon, is of great orthopaedic interest as it has certain characteristics that differentiate it from idiopathic scoliosis starting after the age of 2. The average age at diagnosis is 15 months; it occurs equally in boys and girls; the curves affect the dorsal spine and the direction of the curve to the left. After the age of 2, girls outnumber boys; less than a third of all curves are dorsal, and with the exception of the lumbar pattern, the curves are predominantly to the right

The prognosis of infantile idiopathic scoliosis is usually poor, for these curves tend to progress from an early age, and since the dorsal spine is affected, the thorax becomes grossly deformed with reduction in vital capacity. In some, however, there is a delay between diagnosis of the scoliosis and the onset of deterioration, even up to 5 or 6 years, in these, the thorax has a better chance of developing, and though at maturity a severe curvature is present, the thorax may be well developed, with little functional impairment. On average these curves deteriorate by radiological measurement at about 6 degrees per year, and at the age of 16, the average major curve measurment is over 100 degree. In those that progress from infancy, the major curve may measure as much as 115 degrees by the age of 6, and the prognosis is correspondingly very poor.

Fortunately, not all infantile idiopathic curves are progressive, for in some the curves disappear without treatment within a year or two of diagnosis. This type is termed "resolving infantile scoliosis;" it is frequently, in the early months, similar to the progressive type, and may present a problem of diagnosis, time always provides the answer.

JUVENILE IDIOPATHIC SCOLIOSIS

Idiopathic curves with an onset between 2 and 10 years are relatively uncommon. The curves may be of the dorsal, dorso-lumbar or combined

patterns, and, as stated above, girls are more frequently affected than boys—they tend to progress at a fairly constant rate, with the result that the earlier the curve starts, the more severe the deformity is likely to be at maturity.

ADOLESCENT IDIOPATHIC SCOLIOSIS

Fifty per cent of all structural scoliosis is of this group and 40 per cent of the curves are of the lumbar pattern. This is in contrast to the earlier age groups in which this pattern is rarely seen. The remaining 60% of curves are equally divided between the other curve patterns.

Deterioration occurs while growth continues, the rate remaining constant until near the end of the growth period when it falls. Lumbar curves tend to deteriorate at a slower rate than the other curve pattern, and thus are milder; the average curve measurement at maturity being about 30 degrees, whereas for the dorsal and dorso-lumbar patterns the average is nearly 60 degrees. In the combined pattern the two curves deteriorate at much the same rate.

PARALYTIC SCOLIOSIS

Scoliosis occurs in about 5% of all cases of paralytic anterior poliomvelitis and especially in those in whom there is a severe degree of residual paralysis, though in rare cases the scoliosis may be the only significant effect of the disease. The onset of the curvature is usually within a year of the acute infection.

The incidence of paralytic scoliosis closely follows the agre incidence of *APM* and consequently is more common in the juvenile and adolescent age groups than in infants; there is no significant involvement sex difference. The curves are predominantly dorso-lumbar in pattern and tend to be longer with more vertebral involvement than in other types of progressive scoliosis. It is commonly believed that muscle imbalance is caussive factor in the development of the curvature.

In general the younger the onset of the curve, the more severe the ultimate deformity, although there are wide variations in the rate of progression amongst individual cases with similar age of onset. This may be expected from a disease in which the extent and degree of paralysis is so variable. Even so, the average rates of progression are 20% faster than idiopathic scoliosis of similar age groups.

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SCOLIOSIS SECONDARY TO OTHER CONDITIONS

Scoliosis secondary to Neurofibromatosis, Cerebral Palsy, Syringomyelia, and the Muscular Dystrophies are, in general, rare, and for the reasons of simplicity have been excluded from consideration.

The Symptomatology of Scoliosis

1. *Decompensation.* Decompensation is a defect of posture. In a well compensated scoliosis, the secondary curves above and below the major curve tend to neutralize the lateral displacement caused by the major curve, and the occiput remains over the sacrum in the erect position. In a decompensated scoliosis there is inadequate compensation in the secondary curves, and the patient, in order to maintain his posture, attempts to supplement the compensation of the secondary curves by tilting his pelvis. This effected by flexing one knee (producing apparent shortening of a leg), or alternatively standing with one foot in the equinus position. The degree of decompensation varies with each curve pattern, in the double structural pattern the mechanical effect of one curve is neutralized by the other, and decompensation is unusual. In contrast with long dorsolumbar curves the natural correction produced by the secondary curves is frequently inadequate, resulting in decompensation which may produce severe disability.

Instability. Instability of the spine is essentially a symptom of paralytic scoliosis, especially late onset. In idiopathic and congenital scoliosis the curves are rarely unstable. This symptom is demonstrated clinically by lifting the erect patient off the floor by head traction, if there is any significant instability telescoping of the spine will be observed.

Pain. Pain is a common symptom of scoliosis in later life, and may be due to osteoarthritis degeneration in the spine, or alternatively nerve root compression.

In the growing child, pain is an unusual symptom, and if present, one should suspect a coexisting condition such as a spine tumour.

The Cosmetic Disability. The commonest complaint of patients with scoliosis concerns their appearance. Decompensation, inequality of shoulder height, prominent hip and the thoracic cage deformity are the major contributing factors. As stated above, the degree depends on the curve pattern, and its severity. In early onset scoliosis, besides the disproportion of the thorax to the rest of the body, the whole body may be undersized, due to a generalized failure of growth and development.

Paraplegia. This is a grave complication, occurring in less than 1% of all significant structural scoliosis. It is more commonly associated with congenital scoliosis than with idiopathic or paralytic, and is usuallly due to pressure of the spinal cord over the bony apex of the curve.

The Functional Disability. Decompensation, instability and pain cause functional disability, but without doubt the greatest factor is the thoracic cage deformity; the severity which determines the vital capacity of the lungs. In severe dorsal scoliosis the thorax is small, the ribs distorted, and due to their increased fixation, the breathing is mainly diaphragmatic, with the result that these patients are more prone to respiratory infections, and in later life cardiac insufficiency, both contributing factors to the significant mortality of the disease.

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The Joint Meeting for 1967 of the Maryland Society of Internal Medicine and the Section of Internal Medicine of the Baltimore City Medical Society will be held on Monday, October 2, 1967 at 8:15 p.m. in the Osler Hall of the Medical and Chirurgical Faculty building at 1211 Cathedral St., Baltimore, Md.

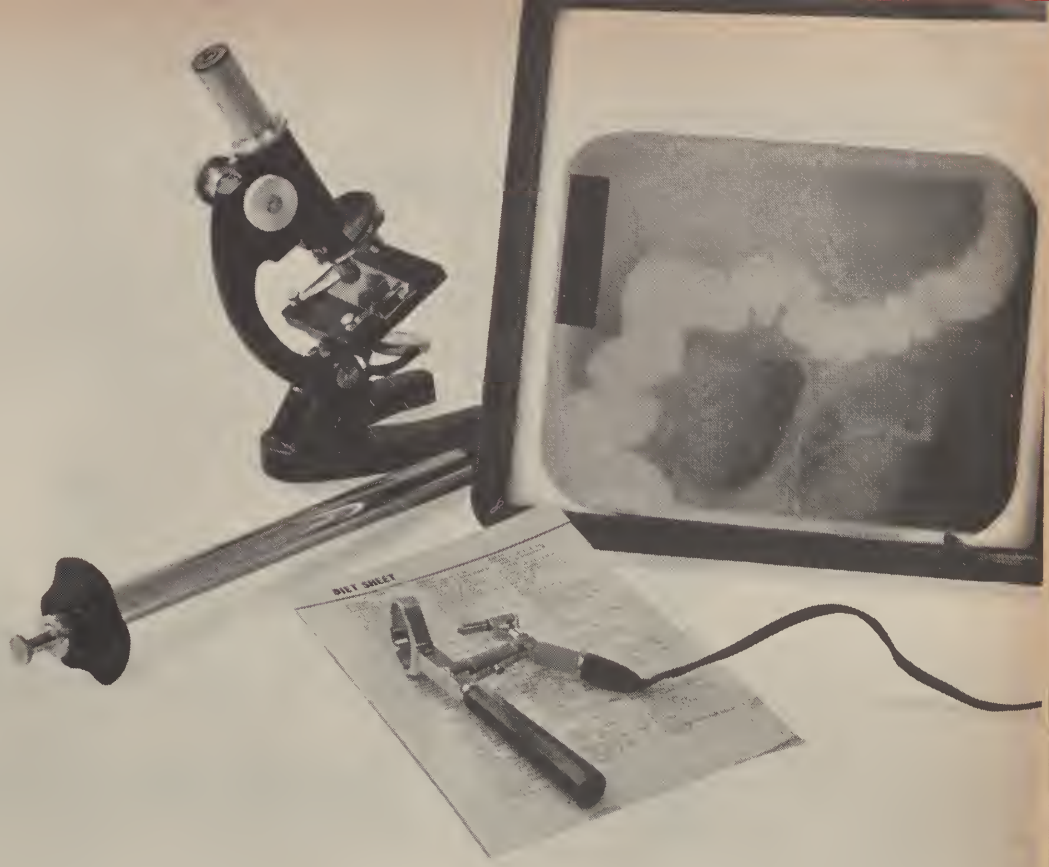
These are crucial years for medicine and internists in particular. In keeping with the basic concepts of the American Society of Internal Medicine, this year's program will feature socio-economic topics of current interest.

Speakers for this meeting include: Richard Wilbur, MD, Chairman of the Board of California Blue Shield. His topic will be, "Who Says It's Reasonable?"

Jerome Chamovitz, MD, Member of *ASIM's* Committee on Labor and Management. His topic will be, "Current Labor Viewpoints Toward Health Insurance."

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Precautions: *Pregnancy.* No teratogenic or embryotoxic effects attributable to the use of Talwin have been seen in extensive reproductive studies in animals; however, like all new drugs, Talwin should be given with caution to pregnant women. A large number of patients in labor have received the drug with no adverse reactions other than those that occur with commonly used strong analgesics. However, as with other strong analgesics, Talwin should be used with caution in women delivering premature infants.

Ambulatory Patients. Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

Certain Respiratory Conditions. The possibility that Talwin (brand of pentazocine) may cause respiratory depression should be considered in treatment of patients with bronchial asthma. Talwin (brand of pentazocine) should be administered only with caution and in low dosage to patients with respiratory depression (e.g., from other medication, uremia, or severe infection), obstructive respiratory conditions, or cyanosis.

Patients Dependent on Narcotics. Because Talwin is a narcotic-antagonist, patients dependent on narcotics and receiving Talwin may occasionally experience certain withdrawal symptoms. Talwin should be given with special caution to such patients. It has been observed that some patients previously given narcotic-analgesics for one month or longer had mild withdrawal symptoms when the drug was replaced with the analgesic, Talwin. After a short period of adjustment the subjects were usually able and willing to continue taking Talwin, and relief of pain was satisfactory.

Nonaddicted Patients Receiving Narcotics. Symptoms believed to be indicative of antagonism to the opiate may be observed rarely with administration of Talwin to patients receiving opiates for a short time. Intolerance or untoward reactions are seldom observed after administration of Talwin to patients who have received single doses or who have had limited exposure to narcotics.

Impaired Renal or Hepatic Function. Although laboratory tests have not indicated that Talwin (brand of pentazocine) causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment. Extensive liver disease appears to predispose to greater side effects (e.g., marked apprehension, anxiety, dizziness, sleepiness) from the usual clinical dose, and may be the result of decreased metabolism of the drug by the liver.

Myocardial Infarction. As with all drugs, Talwin (brand of pentazocine) should be used with caution in patients with myocardial infarction who have nausea or vomiting.

Biliary Surgery. Until further experience is gained with the effects of Talwin on the sphincter of Oddi, the drug should be used with caution in patients about to undergo surgery of the biliary tract.

Adverse Effects: Talwin is relatively free from the undesirable side effects associated with morphine, such as constipation, urinary retention, or severe respiratory depression. Furthermore, Talwin produces less nausea, vomiting, and diaphoresis than meperidine.

In over 12,000 patients who received Talwin intramuscularly, subcutaneously, or intravenously, nausea, the most frequent adverse effect, occurred in approximately 5.0 per cent. In decreasing order of occurrence were vertigo, dizziness or lightheadedness; vomiting; and euphoria. Respiratory depression was reported as an adverse reaction in 1.0 per cent.

The incidence of each of the other adverse effects was well below 1.0 per cent: constipation, circulatory depression, diaphoresis, urinary retention, alteration in mood (nervousness, apprehension, depression, floating feeling), hypertension, sting on injection, headache, dry mouth, flushed skin including plethora, altered uterine contractions during labor, dermatitis including pruritus, dreams, paresthesia, and dyspnea occurred rarely after administration of Talwin (brand of pentazocine). Furthermore, each of the following adverse reactions occurred in less than 0.1 per cent: tachycardia, visual disturbance (blurred vision, diplopia and nystagmus), hallucinations, disorientation, weakness or faintness, muscle tremor, chills, allergic reactions including edema of the face, taste alteration, insomnia, diarrhea, cramps, and miosis; laryngospasm in one patient.

Talwin has not produced severe respiratory embarrassment in adults (never apnea), even with large amounts. A small number of newborn infants whose mothers received Talwin during labor had transient apnea. The incidence of temporary diminution in the rate or strength of uterine contractions is low after administration of Talwin, similar to that following meperidine hydrochloride. (In reporting no interference with normal labor in patients receiving Talwin, one investigator further stated that the drug may increase uterine activity.) Generally, no significant fetal heart rate change occurs.

Laboratory tests of blood and of liver and kidney functions have revealed no significant abnormalities. A minimum and probably insignificant increase in the per cent of eosinophils in peripheral blood counts and bone marrow occurred occasionally.

Talwin is well tolerated by patients with diabetes mellitus, and no changes in insulin requirements have been observed.

Dosage and Administration: *Adults, Excluding Patients in Labor.* Average recommended single parenteral dose is 30 mg., by intramuscular, subcutaneous, or intravenous route; may be repeated every three to four hours. Pain has been relieved in most patients with not more than three doses daily. Infrequently, selected patients have received single doses as high as 60 mg. *Patients in Labor.* A single, intramuscular 30 mg. dose has been most commonly administered. An intravenous 20 mg. dose has given adequate pain relief to some patients in labor when contractions become regular, and this dose may be given two or three times at two- to three-hour intervals, as needed.

Children Under 12 Years of Age. Since clinical experience in children under twelve years of age is limited, the use of Talwin (brand of pentazocine) in this age group is not recommended.

Duration of Therapy. Patients with chronic pain who received Talwin for prolonged periods (e.g., over 300 days) experienced no withdrawal symptoms even when administration was stopped abruptly; furthermore, there was no tolerance to the analgesic effect.

CAUTION. Talwin should not be mixed in the same syringe with soluble barbiturates because precipitation will occur.

Treatment of Overdosage or Respiratory Depression. Talwin has not produced apnea or severe respiratory embarrassment in adults, even in large doses. Occasionally, however, moderate respiratory depression may occur. Means of maintaining proper oxygenation should be available in case of overdosage or respiratory depression, and methylphenidate (Ritalin®) should be administered parenterally. The usual narcotic-antagonists, such as nalorphine, are not effective respiratory stimulants for depression due to Talwin.

How Supplied: ***Ampuls of 1 ml.,*** **containing Talwin® (pentazocine) as lactate equivalent to 30 mg. base and 2.8 mg. sodium chloride, in Water for Injection. Boxes of 10, 25, and 100.**

Multiple dose vials of 10 ml., **each 1 ml. containing Talwin (pentazocine) as lactate equivalent to 30 mg. base, 2 mg. acetone sodium bisulfite, 1.5 mg. sodium chloride, and 1 mg. methylparaben as preservative, in Water for Injection. Boxes of 1.**

The pH of Talwin solutions is adjusted between 4 and 5 with lactic acid and sodium hydroxide.

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(1150M)

When moderate to severe anxiety strikes home...

(the agitated geriatric)

His teen-age granddaughter won't invite friends home because of his outbursts.



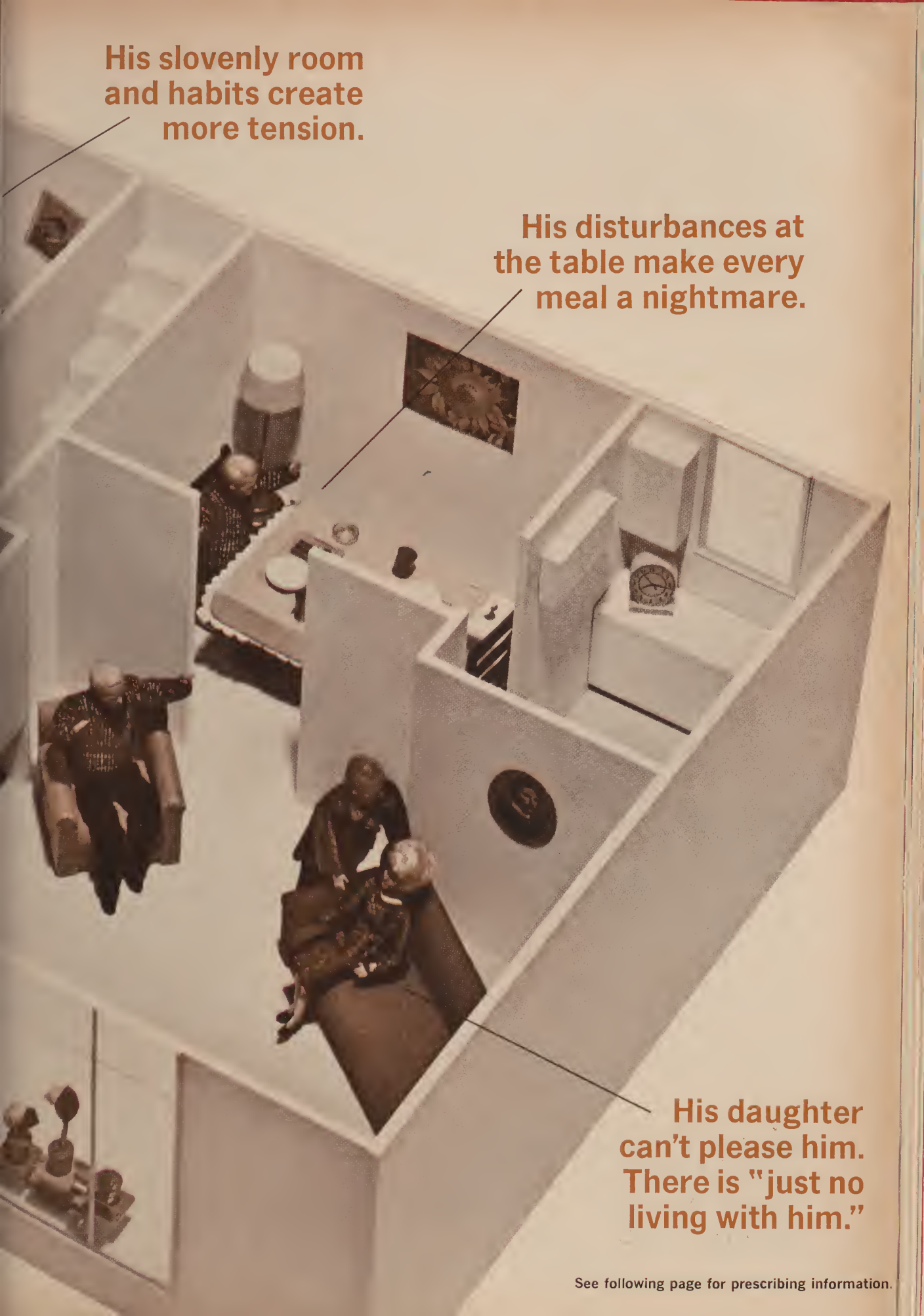
for moderate to severe anxiety

Mellaril®

(thioridazine)

25 mg. t.i.d.

SANDOZ



See following page for prescribing information.

When moderate to severe anxiety strikes home...

Anxiety that *seriously interferes* with the individual's performance at work, at home, or in the community may be regarded as *moderate to severe* in degree.

Mellaril often recommends itself to the treatment of moderate to severe anxiety because it

- helps control the most frequent symptoms: marked tension, agitation, apprehension, restlessness, hypermotility
- often alleviates anxiety-induced somatic complaints
- frequently helps strengthen emotional resources
- helps the patient maintain realistic contact with environment, closer harmony with family

Thus, when you consider the anxiety moderate to severe... consider Mellaril.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

Before prescribing, see package insert for full product information.

for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

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for

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- CHRONIC BRONCHITIS
- BRONCHIECTASIS

The fast-disintegrating uncoated tablet gives relief in 15 minutes

Each tablet contains:

Potassium Iodide	195 mg.
Aminophylline	130 mg.
Phenobarbital, Caution: May be habit forming...	21 mg.
Ephedrine HCl	16 mg.

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Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

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the HEART PAGE
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Elijah Saunders, MD—*Editor*

Current Surgical Treatment of Congenital Heart Disease in Infants—Part II

JOSEPH S. McLAUGHLIN, MD
SAFUH ATTAR, MD
R ADAMS COWLEY, MD
Division of Thoracic Surgery,
Department of Surgery,
University of Maryland School of Medicine

Vascular Rings

These anomalies of the great vessels mimic the embryonic vasculature and take a variety of forms. Most common is the double aortic arch: less common is the right aortic arch with a left ligamentum arteriosus. Less common, but notorious as the cause of dyphasia lusoria is an anomalous right subclavian artery arising from the descending aorta and passing posterior to the esophagus and trachea.

The clinical importance of these lesions lies in their ability to constrict the esophagus and trachea; however, the degree of obstruction is quite variable and many of these patients are asymptomatic. The presence of stridor, often relieved by lying the child on its abdomen, and recurrent respiratory infections are common clues to diagnosis and the constricting vessel is usually demonstrable by barium swallow.

Surgical treatment is aimed at freeing the esophagus and trachea by dividing the constricting ring in an area that does not interfere with blood flow. Cineangiography may provide the surgeon with this information prior to operation and thereby greatly expedite the operative procedure.

Ventricular Septal Defect

This is the most common congenital cardiac abnormality and is the most frequent cause of congestive heart failure in infancy. With proper management most of these children will survive until complete repair is possible. However, in those children with large defects or associated anomalies' (frequently patent ductus arteriosus) refractive heart failure and early death is common. While the present mortality rate of complete repair utilizing pulmonary bypass is prohibitive, pulmonary artery banding is a very effective means of palliation and is associated with a low mortality rate. The constricting band about the pulmonary artery accomplishes two purposes: First, by decreasing pulmonary blood flow the pulmonary vasculature is protected; and secondly, the left to right shunt is decreased and the left ventricle is able to function more efficiently. The latter effect is often striking; the child rapidly improves clinically, the heart size decreases and

the digitalis requirement may be curtailed.

In the four patients with ventricular septal defect, three had associated patent ductus arteriosus. In one of these patients, the ductus was the major lesion and following its interruption the pressure in the pulmonary artery fell to the high normal range. Therefore, pulmonary artery banding was not performed. Three of these children survived. The fourth suffered a respiratory arrest 24 hours postoperation and was resuscitated. Although the patient's cardiac status improved markedly, he died seven days later of brain damage and apnea.

Patent Ductus Arteriosus

This common extracardiac lesion is usually well tolerated in infancy, but on occasion the ductus is sufficiently large and the left to right shunt of such magnitude that refractive congestive heart failure results. Under these circumstances, interruption of the ductus is life-saving and is effectively carried out by suture ligature technique, although, on occasion division is indicated. Three infants with patent ductus in severe failure were operated upon. All survived and have demonstrated satisfactory improvement.

Other Lesions

Three other anomalies were seen during the study period. The first was an endocardial cushion defect with a common ventricle, cleft atrioventricular valves and an atrial septal defect. Pulmonary artery banding was planned, but the infant died during the early stages of the procedure. The second child had a patent ductus arteriosus with a right to left shunt through the ductus and lower body cyanosis thought to be on the basis of a preductal coarctation. At operation a ductus was present but a coarctation did not exist. Following occlusion of the ductus, the right ventricular pressure elevated significantly and failure ensued. Postmortem examination revealed pulmonary arteriolar stenosis. The third child was intensely cyanotic at birth and cardiac catheterization demonstrated pulmonary stenosis and an atrial septal defect. The pulmonary valve was divided under inflow occlusion and the child appeared improved. Twenty-four hours postoperation, the child suffered a respiratory arrest and despite artificial ventilation, died twelve hours later.

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Discussion

Early recognition and definition of life endangering congenital heart disease is vital if children so afflicted are to be given a chance to survive. We wish to emphasize the necessity of early cardiac catheterization in the cyanotic child or the child in heart failure.

The magnitude of the problem of congenital heart disease in infants is apparent. These are small, ill children who must undergo major thoracic surgery. The cyanotic infant not only has a severe hemodynamic defect, but the hypoxic state results in anerobic metabolism and produces severe metabolic acidosis. The infant kidney and lung are capable of only minimal, very inefficient compensation for acidosis. Therefore, frequent determinations of arterial blood pH during the operative period and correction of the acidotic state by the intravenous administration of sodium bicarbonate is essential. Superb anesthetic management is vital. Oxygen concentrations must be maintained at maximum, safe levels, and anesthetic agents that cause arrhythmia or myocardial depression are contraindicated. Blood replacement on a mililiter per mililiter basis and strict management of fluid requirements require constant vigil.

Pulmonary complications are frequent, but controllable. Postoperation, these infants are placed in a high humidity constant temperature environment. Pharyngeal aspiration under direct vision using a laryngoscope is carried out routinely. Oxygen by mask is administered prior to and following aspiration. It is our policy to repeat this procedure at six hour intervals during the first 24 hours, at 8 hour intervals the second 24 hours, and thereafter, as indicated. If adequate tracheal toilet cannot be accomplished, an endotracheal tube is passed and aspiration is performed intermittently with respiratory assistance. We have found this manuever to be very effective and minimally traumatic to the fragile infant respiratory tissues.

Fluid requirements in the postoperative state are much less than the usual maintenance requirements. The amount given is dependent upon insensible loss and renal excretory needs, which vary considerably in the first months of life. Generally these children will take glucose water orally 12 to 24 hours postoperation. If this is tolerated, the formula is rapidly increased during a 48 hour period to insure adequate caloric intake.

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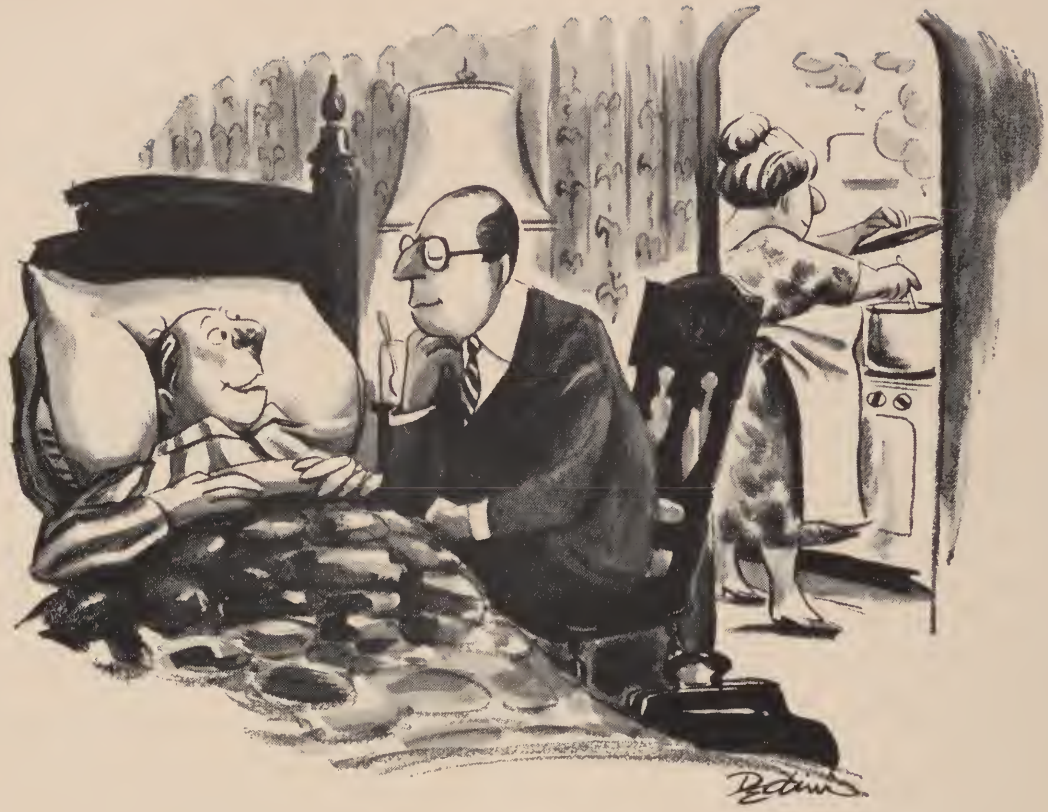
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The overall operative survival rate in this small series is approximately 70% and compares favorably with the 70% survival rate in children less than one year of age at the Texas Children's Hospital and the 60% survival rate at the Toronto Children's Hospital. These encouraging results demonstrate the feasibility of early operative intervention. With the continuing development of operative procedures that completely correct these defects, early recognition and treatment is increasingly essential.



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Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result. Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

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DEPARTMENT OF HEALTH
STATE OF MARYLAND
William J. Peeples, MD, MPH, *Commissioner*

Highlights

Rubella Registry to Identify Handicapped Children

John A. Grant, MD, Chief of the School Health Section of the Division of Maternal and Child Health, reports that actual case-finding of rubella-damaged children may point to a perhaps greater incidence of the syndrome than was originally feared.

Physicians are urged to make particularly close examination of children born between January 1, 1964 and March 31, 1965, whose pregnant mothers may have been exposed during the rubella epidemic of 1963-64, using as criteria for positive diagnosis: (1) Failure to thrive, (2) presence of one or more typical congenital anomalies such as heart defects, defects in vision or hearing, defects in other internal organs, and mental retardation, and (3) a positive HAI antibody titre (greater than 1:32).

The new high-speed HAI (*Hemagglutination Inhibition*) test requires 6-7 cc. of clotted blood in a serology tube, available with mailing container from local health departments. The sample should be labeled "Serology rubella syndrome," and sent to Central Laboratory, 16 East 23rd Street, Baltimore, Maryland 21218.

Rubella is a reportable disease. A positive diagnosis should be reported to the local health department for inclusion in the Rubella Registry, which the Department has undertaken to determine how many rubella-handicapped children will require special treatment and educational facilities now and on reaching school age.

Specialized consultation services are available on a regional basis through strategically located local health departments. Dr. Grant has developed a lecture and slide series on the rubella syndrome, for presentation to county medical societies, hospital staffs, and other interested organizations.

Dr. Garcia to Head D & A Team

The Diagnostic and Advisory teams, which operate regionally under the Division of Crippled Children's Services, have been augmented with the addition of Hector Orlando Garcia, MD, to the staff. A native of Havana, Cuba, where he was engaged in the private practice of pediatrics for a number of years, Dr. Garcia recently completed a two-year fellowship at the Diagnostic and Evaluation Center at The Johns Hopkins Hospital. He is a Fellow of the American Academy of Pediatrics and is certified by the Board of Pediatrics. He received the Gold Medal and Diploma Award in the Scientific Exhibit of the Seventh International Congress of Pediatrics in 1953.

US Gives Aid to Nicaragua in Polio Epidemic

Howard J. Garber, MD, Epidemic Intelligence Officer on assignment to the Division of Communicable Diseases from the US Public Health Service, recently served as technical advisor to the Pan American Health Organization, assisting the Nicaraguan Ministry of Health in its efforts to control a severe polio epidemic. As of mid-July, 400 cases of Type I paralytic polio had occurred,

93% in children under five, with 44 deaths. Epidemiologists estimate that for every case of recognized polio, 100 to 1000 cases were undiagnosed.

Between 400,000 and 500,000 doses of Sabin *trivalent* oral vaccine were administered in the immunization effort, followed by second doses in August. Polio of all three types has been epidemic in Nicaragua in the past six years. Although sporadic immunization programs have been carried out in recent years among school children, Nicaragua has no such program for infants and pre-school children.

Department Aids in Dental Survey

The Chief of the Division of Dental Health recently assisted US Public Health Service, Region III personnel in an evaluation survey of preliminary programming for dental services in two *OEO* Head Start projects, in Westminster and Oakland. Some dentists asked to provide remedial care have criticized previous Head Start dental programs as unrealistic, and attribute this to lack of professional guidance in the initial planning. A nationwide sampling survey is planned, to assist in developing guidelines for lay directors of these projects. It is hoped that improved planning will result in more comprehensive dental care for Head Start children.

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- BALSAM-KROLL-HEIFETZ TRIO
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Maryland Chosen for Health Planning Study

The Department has been awarded a $50,000 contract to test a system of analyzing the effectiveness of state health planning activities. The techniques were developed by the Bureau of Health Services of the US Public Health Service, which awarded the grant.

The study will be performed by an independent research organization, using data compiled by Maryland health agencies during the past five years. The "systems analysis techniques" call for planning around health problems, rather than fixed categories, and were designed in the hope of finding better ways to evaluate health problems, the effectiveness of health services, and the use of manpower and money.

Nursing Homes Press to Conform

Sprinkler manufacturers were overwhelmed with orders from nursing homes attempting to meet the August 1 deadline for installation required by new regulations. The requirement applies to all non-fire-resistive homes having 15 or more beds, those with fewer beds having more time to comply. The Health Department and the State Fire Marshal agreed to accept a valid contract signed and accepted by a sprinkler manufacturer as evidence of a nursing home's compliance with regulations.

Animal Feed to be Regulated

Because of salmonella contamination in the feed of animals destined for human consumption, new regulations are in effect, governing the manufacture of animal byproducts from offal. Monthly laboratory examinations of finished products and routine inspection of plants and operating procedures will be made. Out-of-state products offered for sale in Maryland are also covered by the regulations. The 545 cases of salmonella infection reported last year are believed to represent only a fraction of the true incidence, as many people fail to seek medical attention for a gastric upset.

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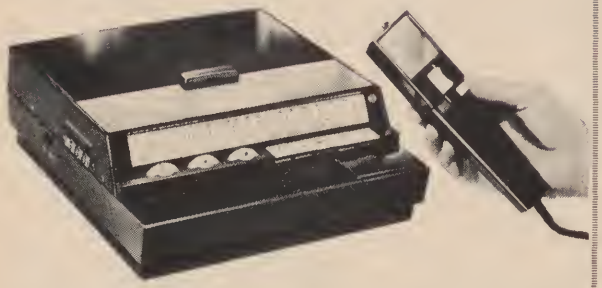
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The reliability of Dulcolax stems from its unique mode of action. The drug works directly on nerve endings in the colonic mucosa, producing normal peristalsis throughout the large intestine. It does not rely on systemic absorption for its effect.

This reliable action provides prompt relief of constipation. It also makes Dulcolax particulary useful for prepping the bowel for special procedures. In short, it makes Dulcolax ideal for your office practice.



Dulcolax acts so surely that the time of evacuation can often be closely predicted. Dulcolax tablets taken at night almost invariably result in a bowel movement soon after waking the following morning. Dulcolax suppositories generally work in 15 to 20 minutes, almost always within the hour.

General Dosage Information: *Adults:* When an ordinary laxative effect is desired, 1 to 3 tablets or 1 suppository usually suffices. Tablets must be swallowed whole, not chewed or crushed, and should not be taken within one hour of antacids or milk. *Children:* 1 or 2 tablets, depending on age and severity of condition. Tablets must not be given to a child too young to swallow them whole. For infants and children under 2 years of age, half a suppository is usually effective. Above this age a whole suppository is usually advisable. Side Effects: As with any laxative, abdominal cramps are occasionally noted, particularly in severely constipated persons. High dosage may result in loose, unformed stools. Contraindication: Contraindicated only in acute surgical abdomen. Availability: Tablets (5 mg.) and suppositories (10 mg.). By prescription or recommendation.

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See next page for a brief precautionary statement.

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chlorthalidone

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Indications

Hypertension

Such as hypertension with or without congestive failure, where Hygroton can be used alone or in conjunction with other agents

(*Precaution:* Antihypertensive therapy with Hygroton should always be initiated cautiously in post-sympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol may potentiate hypotension.)

Edema

Such as edema associated with:
congestive heart failure
or renal disease

(*Precaution:* Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises.)

or hepatic cirrhosis

(Hypoproteinemia, if present, must be corrected concomitantly. *Precaution:* Take special care: discontinue if liver dysfunction is aggravated, since hepatic coma may be precipitated.)

or steroid administration
or obesity
or the premenstrual syndrome
or pregnancy, including toxemia

(*Warning:* Use with caution in pregnant patients, since the drug may cross the placental barrier and adverse reactions which may occur in the adult, e.g. thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc., are potential problems in the newborn.)

Contraindications

Severe Renal or Hepatic Disease and Demonstrated Hypersensitivity

Other general warnings, precautions and adverse reactions

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

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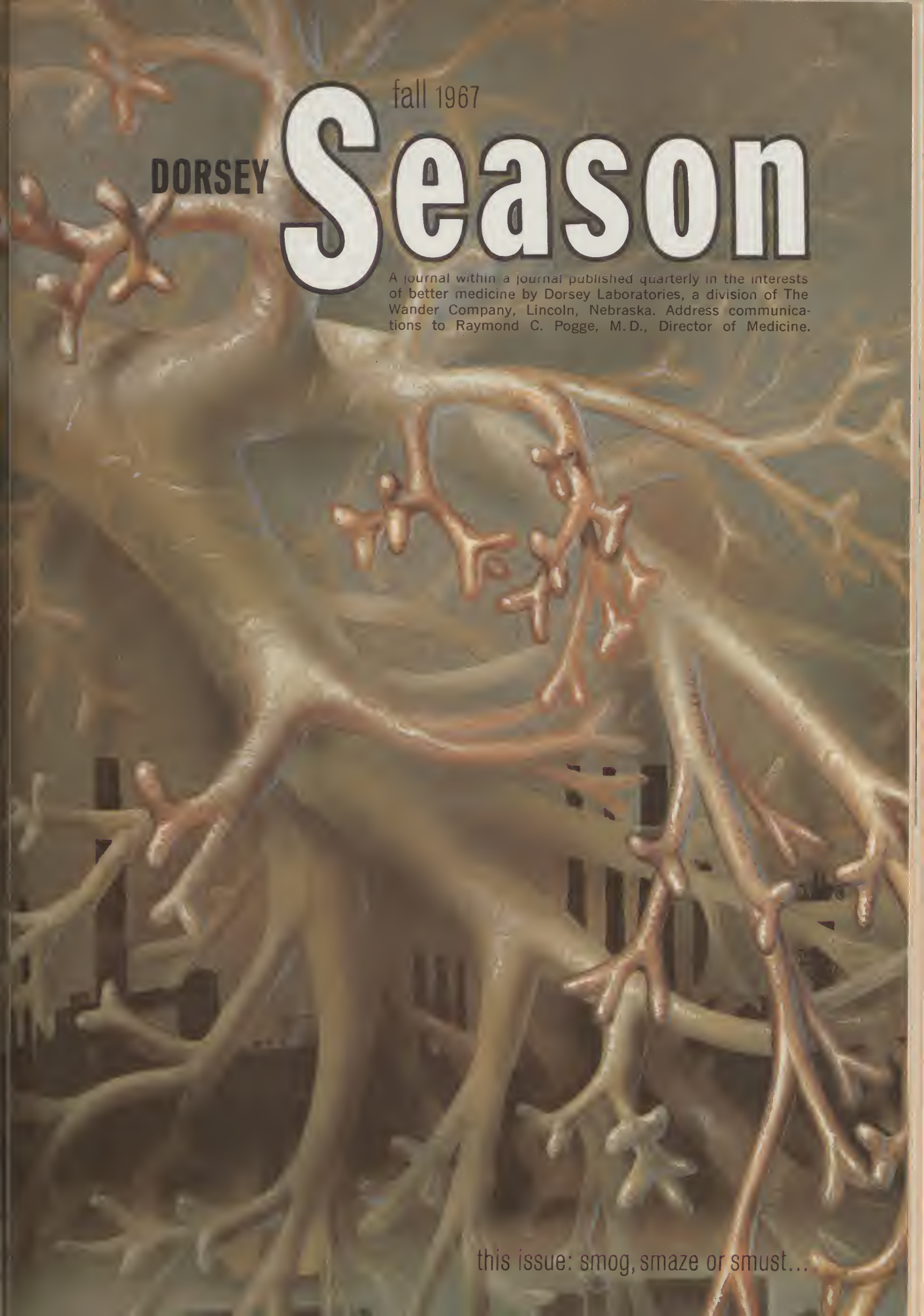
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this issue: smog, smaze or smust...

Smog, smaze or smust...effects of air pollution on upper respiratory tract

Nathan Flaxman, M.D., Diplomate, American Board of Internal Medicine, Chicago, Illinois

In Los Angeles it is *smog* (smoke and fog). In New York City *smaze* (smoke and haze). In El Paso *smust* (smoke and dust). The original factor was smoke plus such natural phenomena as fog, haze and dust, but air pollution has mushroomed from a smoke problem in our industrial cities into a major economic, esthetic and public health problem that affects practically every American locality and citizen.[1,2] Respiratory disease, of course, is by far the most costly effect of air pollution, for contaminated air can aggravate our illnesses, deplete our strength and shorten our life span.[1]

The greatest problem in dealing with solid wastes is that they are not quickly returned to dust. To aid the decomposing process, the great bulk of such waste is burned, polluting our air in the process.[3] Dr. Jack McKee of the California Institute of Technology[4] has calculated that in Los Angeles County, which has more than six million people, about three pounds of gaseous wastes per person per day (on a dry-weight basis) enter the atmosphere. This is twice as much as solid refuse disposal and six times as much as the contaminants in waste water. It is estimated that in New York City, 730 pounds of pollutants, a little over half the size of a compact two-door sedan of foreign make, is annually thrown into the air for each man, woman and child in the city.[5]

Air pollution is an evident factor, not only in the common cold and upper respiratory disease, but also in chronic bronchitis,[2] pulmonary emphysema,[6] bronchial asthma,[7] pneumonitis and lung cancer.[8] Its effect on the incidence of pulmonary tuberculosis is unproved,[9] although it is conceivable that the presence of various materials polluting the air might do this. A siege of smog in Denver, the "mile high city," in December 1965 was accompanied by respiratory infection that doubled normal absentee rates in schools, factories and city government.[10]

While air pollution is only one factor, it has become important in the causes of most of the afflictions of the respiratory tract. This has been shown not only by the Denver occurrence, but also by detailed study[2] of respiratory illness in a small group of 313 men



from October 1962 to May 1963 when there were 202 episodes involving the upper respiratory tract. The attack rate of illness was related in time to increased concentration of both smoke and sulphur dioxide in the atmosphere of the district in which the men lived.

Other factors often mentioned, include exposure to those who have colds, exposure to extreme changes of temperature, allergy and bacterial infection. However, when low individual resistance due to lack of rest, overwork, fatigue, improper or unbalanced diet, previous illness and emotional stress are included as causes, we enter the realm of somewhat obscure relationships. Much more emphasis can be placed on the role of polluted air.

The symptoms, signs and complications of involvement of the upper respiratory tract, especially the common cold, are the same regardless of the causative factor. Swelling of the lining of the nose, the scratchy dry throat, the discharge from the nose at first watery then thicker, discolored and more tenacious, the eyes tearing, and frequent sneezing are all part of the Number 1 human ailment. Concurrent or residual sinusitis when mucus is trapped there, middle ear involvement due to interference with drainage, laryngitis and bronchitis are complications of the common cold. The primary interference is with a most important function of the nose—the cleansing of foreign matter in the first line of "air defense" to prevent it from entering the breathing tract.

However, the diagnosis and subsequent decision on how to treat the patient so affected rests basically on the relief of symptoms that cause him the misery. The stuffed, runny nose, the clogged ears, and the harsh dry cough—all the symptoms that make common cold sufferers feel miserable and interfere with their sleep—can be alleviated with medications of the oral nasal decongestant/antihistamine combination type. The burning sensation in the throat, soreness of the chest and even chest pain can also be relieved by such medication. Rest in bed if there is fever (but confined to home at least), liberal fluids, uniformly warm surroundings and adequate humidity in the room, are all helpful adjuncts to the medication. Most common cold sufferers recover rapidly and are symptom-free in four to ten days.

Further treatment, altered by the fact that the affliction hangs on for more than the usual duration of the common cold, requires consideration of allergy, which is most frequently the prolonging factor. But air pollution itself may often be the culprit.

(Concluded on following page)

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At the Third National Conference on Air Pollution held recently, it was emphasized that this subject had received more attention in the past four years than in all previous history. Spicer,[11] an active participant at this conference, reiterated that it behooves the practicing physician to be aware of trends in respiratory disease and to accept a major role in community action relating to air pollution and respiratory health. By taking a positive stand physicians have been instrumental in the development of anti-pollution legislation. An outstanding example is Los Angeles where major steps have been taken by abolishing coal burning, and even banishing oil burning, seven months a year. Natural gas must be used instead and it must be used by industry when available. Backyard incinerators have been abolished in favor of landfill disposal, and building incineration ended except for a few expensive smokeless furnaces.[10] Concerted action can be taken against particular industrial nuisances. One company that disregarded complaints discovered its error when thousands of its credit cards were returned by irate customers who decided to patronize competing companies.[12]

Summary. Respiratory disease is the most important and most costly effect of air pollution, whether termed smog, smaze, or smust. Air pollution is an economic, esthetic and public health problem that affects practically every American locality and citizen. New sources of air pollution are invisible and odorless, but the harmful gases and liquid droplets are there. Triggered by sunlight, some of these undergo mid-air chemical changes and the results are even more irritating to the upper respiratory tract. The symptoms, signs and complications, especially of the upper respiratory tract, can be readily aborted by modern medication but may be unduly prolonged by polluted air. In steps taken to prevent this, the practicing physician can take a major role.

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Alcoholism SECTION

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

Public Health Responsibility for the Alcoholic. Part II.

DAVID TRACHTENBERG, MD

Court Decisions

In last month's issue (Part 1) I said we are obliged to set up treatment programs; if not morally and professionally, then finally legally. In the recent past there have been two federal court decisions in this area concerning the status of the alcoholic. One in the Fourth Circuit Court of Appeals in Richmond and another in the Federal Court of Appeals for the District of Columbia. There is at the present time, on its way to the Supreme Court, a similar test case which will affect the status of the alcoholic on the national level. In my opinion the Supreme Court will most certainly affirm the decisions of these two lower courts, and what will happen when the jails are no longer available as our primary treatment source? What will we have for these people on the day when our local courts begin to turn them over to us? In Montgomery County in the 18 months ending June '65 there were 1781 individuals convicted on the charge of public drunkenness alone. Of these, some 780 individuals were convicted more than once within a twelve month period, some up to 16 times in 12 months.

The experience in Washington is a good example of what can happen. The present situation resulted from a decision some time ago when the courts took the action that they never took previously. As a result, unprepared treatment facilities in the District have been completely overwhelmed. I am told that all real treatment programs have, in fact, broken down under the impact of these tremendous numbers of people. It would be unwise not to prepare and leave ourselves open for the tremendous difficulties that public health officials in the District are now suffering, not to mention the alcoholics themselves.

I have heard of a plan, where alcoholics will be disposed of by civil commitment for six months to two years, and thus, be salted away more effectively even than through jail. It is the opinion of Mr. Peter Hutt, the lawyer who represented Mr. Easter in the District, that civil commitment will also be found to be unconstitutional. He states, "I have grave doubts, however, about the constitutionality of wholesale civil commitment of chronic alcoholics. We have not fought for two years to extract Easter, Joe Driver, and their colleagues from jail, only to have them involuntarily committed for an even longer period of time, with no assurance of appropriate rehabilitative help and treatment. . . . The euphemistic term 'civil commitment' can easily hide nothing more than permanent incarceration. Thus I would caution those who might rush head-long to adopt civil commitment procedures, and remind them that just as difficult legal problems exist there as with the ordinary jail sentence." I would likewise advise you not to count on civil commitment for very long.

The alcoholics are out there, and we are going

Presented by David Trachtenberg, MD, psychiatrist, Chief of the Bureau of Alcoholism and Drug Addiction, Montgomery County Health Department, on June 1, 1967 before a section of the Maryland Public Health Association.

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to be obliged to treat them, therefore what would good treatment be? What is needed? Let me divide the services into four broad areas.

Education

At the present time education, in addition to the treatment of alcoholism itself, represents our only means of prevention. It is essential that we inform the general population about the prevalence of alcoholism and its early signs. This in itself will be useless without a major effort on our part to change the emotional attitudes of the public toward alcoholism as a disease. Everyone must understand that the only shameful thing about alcoholism is to have it and know it and not have it treated. The alcoholic must be seen as suffering from an illness that he is unable to handle. The use of alcohol must itself be separated in the public mind from its association with masculinity, and from its necessary connection with swinging or celebrating or having a good time.

Attitudes towards drinking have been demonstrated repeatedly to be the most important element in the establishment of drinking *practices*. This can be seen clearly in cross-cultural studies of drinking practices. Note the traditional Irish attitude, that alcohol is to be used to celebrate and to get high, as a mechanism toward freedom and escape. In the Chinese or Jewish or Italian cultures alcohol is used freely, but it is clear in each culture that drinking is to be controlled and used in solemn family ritual rather than to produce euphoria. In these last three cultures, while drinking is encouraged, there are strong sanctions against drunkenness. The individual who overimbides is subject to the ridicule of his group. As one would expect, the incidence of alcoholism is far higher among the traditional Irish than among the other three groups. The development of responsible attitudes toward the use of alcohol, which takes into account actual social practices, is in my opinion the most important prerequisite to prevention of alcoholism.

If the general public must be educated, with particular emphasis of course on the adolescent, so also the professional caretakers must be made aware of the extent of the problem and particularly of their own prejudices about alcoholism. It has been said that alcoholism is the most frequently undiagnosed disease. I am certain this is so. This reflects several things in my opinion. First, the lack of awareness on the part of caretakers of the real prevalence of this illness; second, the feeling of futility on the part of caretakers toward alcoholism; and third, the anxiety which many of us feel about our own drinking.

Therapeutic Services

Recently I read of a physician who had divided alcoholics into four groups: the good, the bad, the mad, and the sad. In this way, he is separating those alcoholics which continue to be productive members of the community who will gradually come to depend on alcohol; those psychotics who use alcohol as self-medication; the psychopath whose excessive use of alcohol is part of a broader anti-social adjustment, and lastly those people with acute or chronic depression who use the alcoholic oblivion to make life bearable.

This simple classification itself would require a number of different treatment approaches in our efforts to manage the disease. If we separate these groups again into those who, for example, are still living with their families and those who are not; or those who require vocational rehabilitation or training and those who do not; those who have severe medical complications and those who do not; and those whose families are disorganized and those whose families are intact, you can see that we end up with quite a grid, each item on which requires a somewhat different treatment approach.

Obviously what is needed is a *system* of service broad enough to provide continuity as the alcoholic progresses through the various phases of his illness, and also to handle the spectrum of specific problems, tailoring the program to the needs of each individual family. Incidentally, I keep saying "family." This is intentional because alcoholism, except in its very earliest stages, is clearly a family disease. It cannot be approached on the individual level in most instances.

The system of services which I am proposing begins with an inpatient unit which offers four services:

1. A detoxification unit in which the patient would be expected to remain for 48 to 96 hours. Here, physical examination, diagnosis, and treatment of acute alcohol poisoning will be conducted.
2. A hostel where alcoholics can stay for a few days under supervised conditions should they

refuse more intensive treatment, but still require shelter. Alcoholics might be admitted to the hostel directly by the police as an alternative to jail or through the detoxification unit if their clinical condition requires.

3. Halfway house facilities for both men and women within the community which alcoholics can use as a base of operations during the time in which they are recovering from their intermediate brain syndrome, the phase between acute intoxication and full functioning. In the halfway house the alcoholic would be exposed to broad and intensive diagnostic procedures which would include a psychological and physical evaluation, family diagnosis, and vocational analysis. During his stay in the halfway house the patient's family would hopefully be brought into the treatment program and would also receive intensive assistance. An alcoholic might be expected to remain in the halfway house for from 3 to 12 weeks. During that period he would begin a job or vocational training. In addition, he would be expected to profit from the group living, with heavy emphasis on milieu therapy. Toward the end of his stay the halfway house would, in fact, function as a night hospital.

4. For those who require long-term hospitalization we might depend on the state hospitals which would be free of the burden of caring for the transient, rapid turnover group and could thus concentrate their resources on long-term treatment. Following a stay in the state hospital the alcoholic might then come to the halfway house or go directly into the community as the situation dictates.

Outpatient Treatment

Outpatient treatment must be available for the alcoholic and his family. Those who did not require inpatient treatment would, of course, be picked up directly in the outpatient clinics.

Community outpatient clinics already exist in many communities. Some have very few alcoholic patients. It is my opinion that where this is true, it is the responsibility of the clinic and not of the alcoholics. We have found that our patient load varies directly with our effort to reach various community agencies and make them aware of our program to provide them with consultation in

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their efforts with these people. The outpatient clinic is a keystone in our local treatment program but alone it is not enough.

A day hospital would be part of the outpatient facilities. In addition, individual and family psychotherapy and supervision would be carried on. Adult education courses might be brought into the outpatient facilities specifically in terms of family planning, money management, social skills, etc. It is amazing to note how many of the families we deal with do not have even rudimentary information about how to run a family.

Vocational Training

Vocational training is an essential part of the overall rehabilitative process. Any alcoholic program requires full-time vocational rehabilitation service at every level, rather than as a pretermination referral.

Obviously the variety of treatment services I have proposed cannot become a program without effective and imaginative leadership at the program director level. The program director's office, in addition to the ordinary administrative functions, must be charged with the critical responsibility for community coordination. Without constant and strenuous efforts to reach the various caretaking agencies and citizens groups, any alcoholism program will fail. We must not only motivate the patients and their families, we must motivate the motivators. We must teach the various social agencies about alcoholism, help them to examine their own attitudes about the disease, and finally demonstrate to them that their efforts in referring patients and working with those people in the program will be rewarded by a sharply rising success rate. We have found that the community coordinating, or organizing if you prefer, functions are among the most important offered in the program. The more we look for patients the more we find, and the more we involve in a coordinated comprehensive treatment program the more we help.

Role of the Public Health Services

We have talked about who the alcoholic is, where he is, what is happening to him now, what we should have to offer him. What specifically can be the role of public health services in establishing and maintaining alcoholism programs?

It is at this point that I must confess that I wear two hats. That is, while I am half-time with Montgomery County Health Department, I am



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also in private practice in psychiatry. I consider that I have a vital interest in private medicine as well as public health. My point of view then reflect my own efforts to integrate both of these, if only for my own mental health. With the exception of some outstanding achievements in prevention of infectious diseases, it seems to me that public health agencies have been the firemen and more often the garbage collectors of the medical community. In recent years, with increasing federal aid and emphasis on large scale research, the picture appears to be changing and public health agencies are moving into the forefront of American medicine. This is as it should be. You have the money and more important you have the big picture and so it should be with alcoholism programs. It must be the public health agencies, with the money to construct adequate facilities and with the staffs available to evaluate programs that must take the lead.

Any good salesman will state as one of the primary principles of selling that he must create a demand for his product. It is the health departments that must create the demand for adequate alcoholism and, incidentally, drug abuse programs. You must make your communities aware that alcoholism is a disease that can be successfully treated. Welfare departments, schools, and other community groups must be shown how to spread the word and they must be helped in examining their own attitudes about the disease.

It is the law in Maryland that junior high school and high school children be exposed to a course which includes information about alcohol, smoking, etc. These courses are often inadequate, concerning themselves with the chemistry of alcohol, for example, rather than alcohol as a significant social phenomenon. Not enough attention is paid to who are doing this teaching and what their attitudes are. The goals of teaching, that is, what we are really trying to say to these young adults must be more clearly formulated and evaluated and there must be some way of testing the effectiveness of our efforts.

Construction of facilities as a practical matter can be effectively accomplished through local governmental agencies. Hospitals are expensive to build and maintain and, with State and Federal aid, public health agencies are, in my opinion, in the best position to create them.

Supervision of facilities, the publishing of models plans and the final evaluation of individual programs should be supervised by your local health departments, not only to safeguard the public from abuses but even more important, to provide positive leadership and example for those who are in this who are working in the area. Finally, where the private sector is not yet providing even minimal service, or where services are required which are difficult for people in private medicine to organize, then these services can be provided through the health department. Day Care Centers, for example, or family therapy groups, vocational rehabilitation, welfare, can probably best be coordinated on the public health level.

Finally, having initiated programs and having provided leadership, having educated the professional and lay community about alcoholism, the final goal of the public health agencies should be to pull out, to turn the programs and the facilities, wherever possible, over to the private sector so that extended interests along other frontiers may be explored and the process repeated. In this way, public health can never again become the sometimes stale sedentary bureaucratic garbage dump that it has seemed to be.

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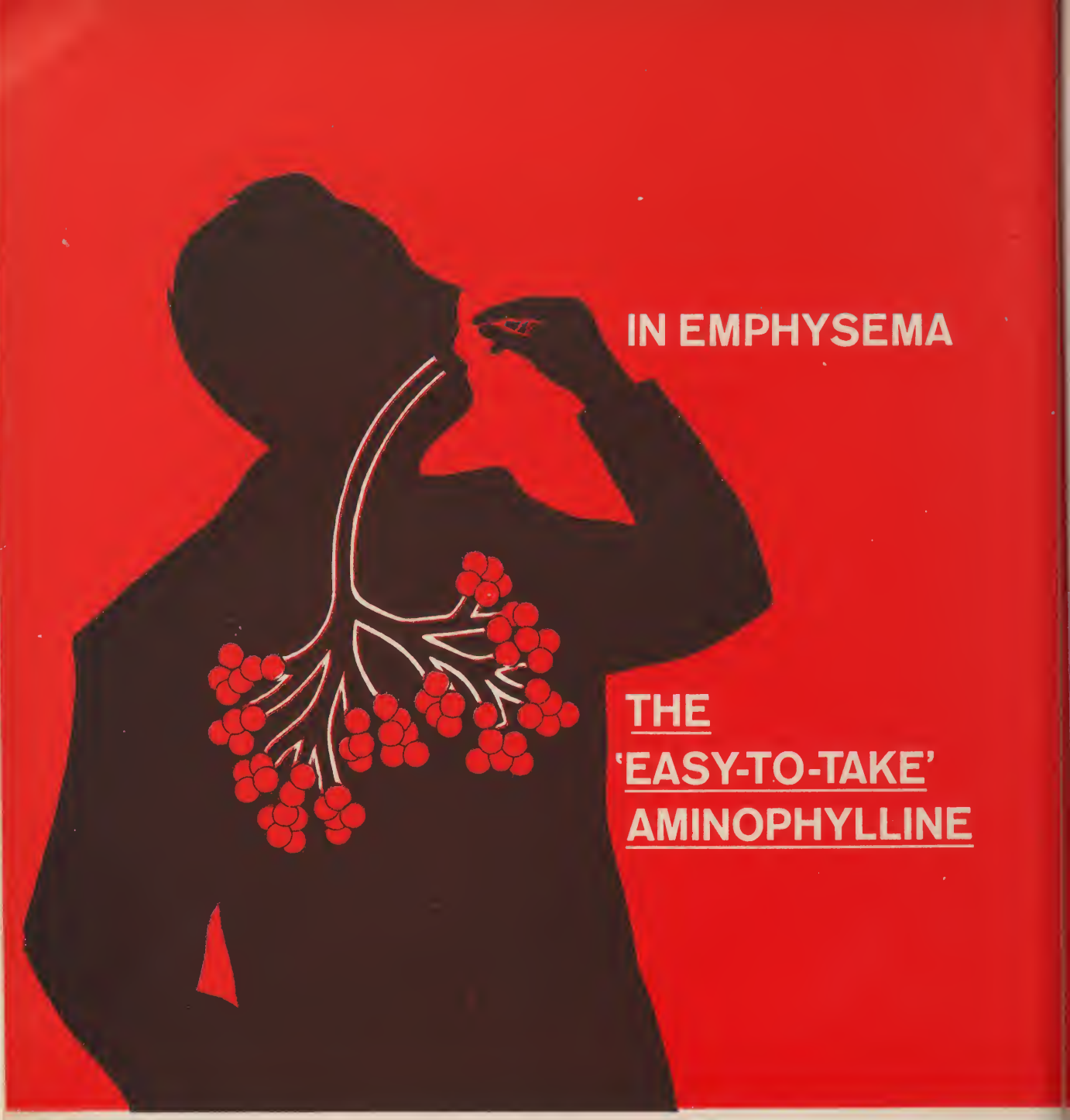
Fact Sheet for 1967 Fiscal Year

In 1967 Maryland's hospitals for the mentally ill again treated a record number of patients, reflecting the continuing rise in admissions. In 1958 these facilities treated 16,197 patients; by 1967 this had increased 41.4% to 22,897. However, due to shortened periods of hospitalization and the continuing decrease in the number of long term patients, the average daily size of the patient population declined 12.5 percent during this period from 9,530 to 8,006. Detailed data are shown in the following table—

A similar upward trend has been observed in virtually all of the 101 clinics and other outpatient centers reporting to the Maryland Psychiatric Case Register. Total admissions to these facilities are estimated to have increased 10.0% from 14,691 in 1966 to 16,161 in 1967. Since comparable data have been reported by most states, the question is frequently posed whether or not this reflects a rising incidence of mental illness. This can not be readily answered since the numeric relationship between the number of individuals treated in psychiatric facilities and the total number of mentally disturbed or ill can not be determined. However, it is generally believed that the rate of occurrence of most mental illnesses has not changed appreciably and that these expanding figures therefore primarily reflect the growing acceptance and usage of psychiatric hospitals and clinics as short term intensive treatment facilities for alcoholism and acute psychoneurotic and personality disturbances.

Substantial overcrowding continued at Rosewood, the larger of Maryland's two hospitals for the mentally retarded. It therefore persisted in its policy of relating the number of admissions to available space and staff. Despite this restrictive policy, the average number of retarded patients at Rosewood and Henryton increased 109 to 2,997 last year. Ten years ago, prior to the opening of Henryton, Rosewood had a patient population of 1,865. In an effort to resolve this chronic problem, the Department is engaged in a three-pronged program involving the construction of additional buildings at Rosewood, the establishment of new facilities in the Baltimore and Washington metropolitan areas and the development, with the Health Department, of coordinated community based services as alternatives to hospitalization.

FISCAL YEAR	AVERAGE SIZE OF PATIENT POPULATION	TOTAL NUMBER TREATED DURING YEAR	ADMISSIONS	TOTAL SEPARATIONS
1958	9,147	16,197	4,015	4,412
1960	8,576	16,268	4,640	4,751
1962	8,291	17,580	6,221	6,111
1964	8,035	19,424	7,871	8,104
1965	8,076	19,873	8,551	8,009
1966	8,102	21,542	9,675	9,735
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REHABILITATION Notes

REHABILITATION SECTION
BALTIMORE CITY MEDICAL SOCIETY,

DOUGLAS G. CARROLL M.D.
EDITOR

Hand Function in Quadraplegia

DOUGLAS CARROLL, MD
Chief, Physical Medicine and Rehabilitation
Baltimore City Hospitals

Andersen[1] has pointed out that at least one-third of patients with spinal cord injuries seen in a Veterans Administration Hospital are classified as partial quadriplegics. Although there is a good deal of variation in the pattern of paralysis depending on the level of cord injury, generally there is maintenance of neck muscles, shoulder abductors, elbow flexion, supination of the forearm and wrist extension. Shoulder adduction, elbow extension, forearm pronation, wrist flexion and flexion and extension of the fingers are frequently absent. Loss of shoulder muscle stabilizers and loss of triceps strength is crippling because it prevents the patient from lifting himself in a wheelchair and makes transfer from bed to wheelchair difficult. The maintenance of elbow flexion and wrist extension, however, allows the possibility of use of the hand to bring fairly small objects to the mouth and is helpful in such activities as feeding, shaving, washing and dressing. These actions depend on the use of weak lateral prehension between thumb and index finger on extending the wrist.

Eleven patients with quadriplegia were studied with the upper extremity function test *UEFT*.[2] most cases were caused by trauma but some had, in addition, osteoarthritis of the cervical spine; one was caused by a granulomatous lesion and one was unexplained.

Characteristic Hand Movements in Quadriplegic Patients

Figure 1 shows the maintenance of lateral prehension between the thumb and the lateral side of the proximal interphalangeal joint of the index finger during wrist extension. With this trifling tenodesis action, the patient may be remarkably independent. Figure 2 shows the characteristic way in which this action is used to grasp, and Figure 3 shows the use of this movement in pinch.

Generally the scores on the *UEFT* of the two hands of any individual patient were slightly different. Weakness of grip on dynamometer was universally present, pinch between thumb and the little finger was the most common loss of function. As the impairment became more severe, the ring and middle fingers dropped out as did grasp of the larger blocks. Moderate strength of dynamometer testing and good performance of grasp function were found to be necessary for a patient to control crutch handles.

Return of function was unusual in patients with traumatic quadriplegia. One patient with an idiopathic transverse myelitis of unexplained origin

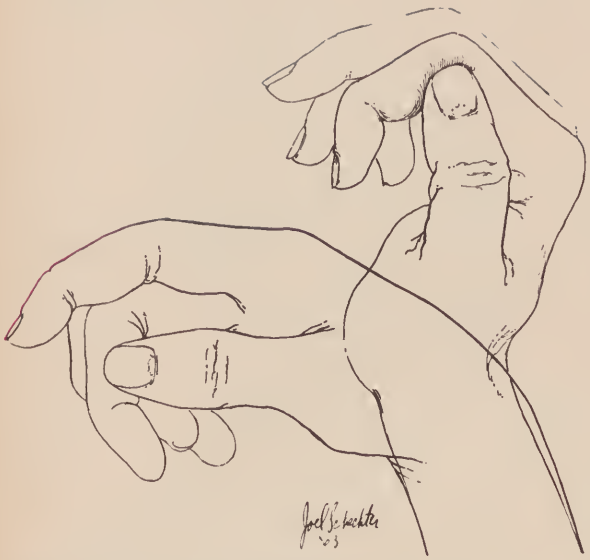


Fig. 1. Tenodesis type action of thumb and lateral side of index finger in Quadraplegia.

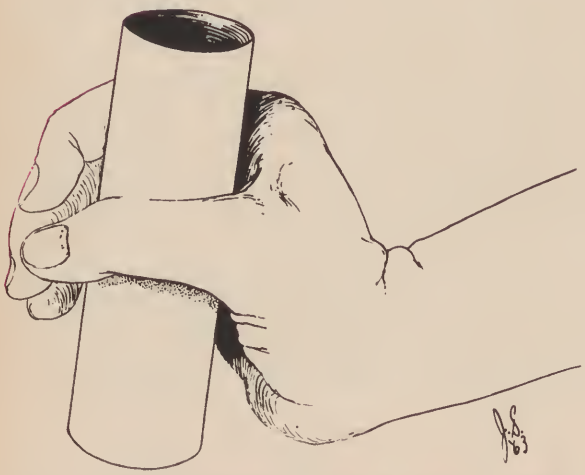


Fig. 2. Use of tenodesis action in grasp in Quadraplegia.



Fig. 3. Use of tenodesis action in pinch in Quadraplegia.

showed gradual increasing hand functioning over a period of about 6 months. The initial loss of function was of two types in this patient. First, there was clumsiness and difficulty with placing the objects onto the shelf. Secondly, there was loss of fine function of the ring and small fingers. Return of function was characterized by improvement in shoulder function without too much change in activities of the fingers. There was also a two to three fold increase in dynamometer grip.

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1. Andersen, V. W. Self-aid Devices and an Evaluation of the Hands in Quadriplegics. *J. Assoc. for Physical and Mental Rehabilitation* **10**: 2: 40 (March-April), 1956.
2. Carroll, D. An Upper Extremity Function Test. *Maryland State Med. J.* **16**: 97 (Feb), 1967.

Woman's Auxiliary

"Team Mates"

Richard Bauer, MD, President of the Maryland State Medical Society and his wife, Randy, Hospitality Chairman of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland, make one of six husband-wife teams serving on Boards in Maryland.

A graduate of Jefferson Medical College in Philadelphia, Dr. Bauer has been in practice in Prince Georges County since 1949. He enjoys directing at the Adelphian Little Theatre of which he was founder and past president.

Randy is a past president of the Woman's Auxiliary to the Prince Georges County Medical Society and is president of the Adelphi Chapter of the American Field Service program.

The Bauers have three daughters: Suzanne, Phylis and Barbara.

A past president of the Maryland Chapter of the American College of Surgeons, John Connolly, MD, was elected president of the Baltimore City Medical Society this year while his wife, Marion, takes over the chairmanship of International Health in the Auxiliary. He is a graduate of Georgetown University and its Medical School, and served in Surgical Hospitals during World War II. In 1966 he was appointed to the Archdiocesan Council of Priests, Religious and Laity by Cardinal Lawrence J. Shehan, and in 1967 was elected to the National Board of Governors of the Alumni Association of Georgetown University, and President of the Staff of St. Joseph Hospital for three years.

Marion who modestly claims a lower rating but undeniably admits to as busy a life rearing seven children—six girls and a boy, likes to play bridge and travel.

* * * * *

In addition to being an office nurse for her husband in a busy small town practice, Ruth Barnhart manages to be the recording secretary in the Auxiliary to the Cecil County Medical Society of which he husband, Jay, is president. They met in his senior year of pre-med at Franklin and Marshall College after she graduated from Lancaster General Hospital Nurses Training in 1957. While he attended Jefferson Medical College, Ruth did private duty nursing in between having two babies—both girls.

After collecting such laurels as membership to *AOA* Honor Society and the award of being the best intern for the year 1961-62 at Lancaster General Hospital Dr. Barnhart decided to hang his shingle in the Northeastern part of Maryland near the Chesapeake Bay where, according to Ruth, there has never been a dull moment.

* * * * *

The Woman's Auxiliary extends a welcome to new Members-At-Large. Our latest members are: Mrs. Howard W. Ash, Frederick County; Mrs. Vernon B. Dettor, Charles County; Mrs. Frederick M. Johnson, Charles County; Mrs. Arturo M. Monteiro, Charles County and Mrs. Thomas R. Reid, Jr, Frederick County.

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MARYLAND ASSOCIATION OF MEDICAL ASSISTANTS

SEPTEMBER, 1967

Medical Ethics Class

Presented by Ian Anderson, MD

On Wednesday, June 21, 1967, Ian Anderson MD, gave a lecture to the Baltimore Association of Medical Assistants on the subject of *Medical Ethics*. This is one of the subdivisions of the Certified Medical Assistant Examination which was given at the University of Baltimore on June 23 and June 24; consequently the lecture was most appreciated by the members of *BAMA* who intended taking that examination this year.

In spite of the fact that this was a very hard to define subject to discuss, Dr. Anderson did a remarkable job of ascertaining the points of information most necesssary to the medical assistant and correlated this most adroitly with bits of medicolegal information along the same line so that the presentation was most helpful. Discussion with the members present followed, and everyone present enjoyed the meeting.

Dr. Anderson is a graduate of the University of Maryland School of Medicine, graduating in June, 1962. He performed his internship and one year of residency at South Baltimore General Hospital. He then joined the staff of Church Home and Hospital in July of 1964. Dr. Anderson is now Chief Resident in Surgery at Church Home and Hospital and will complete his residency June 30, 1968.



IAN ANDERSON, MD

HAROLD ROSEN, MD, GUEST SPEAKER AT THE B.A.M.A. MONTHLY MEETING

At the Baltimore Association of Medical Assistants monthly meeting on June 13, 1967 held at Longley' restaurant in Towson, Harold Rosen MD, presented a very interesting discussion on thes ubject of "Hypnosis." Dr. Rosen introduced

when bursitis hits a 280-lb. tackle, hit back with Butazolidin alka



Indications: Osteoarthritis, rheumatoid arthritis, rheumatoid spondylitis, psoriatic arthritis, acute gout, painful shoulder (peritendinitis, capsulitis, bursitis and acute arthritis of that joint), acute superficial thrombophlebitis.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make regular blood counts. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ul-

For 280-lb. tackles—or 108-lb. housewives—Butazolidin alka can hasten recovery from the agonizing pain of shoulder bursitis.

It's not for every patient. Check carefully the Contraindications, Warning and Precautions shown below.

And adverse reactions may occur. The most common are nausea, edema and rash. Rarely, agranulocytosis has been reported. All adverse reactions are listed below, too.

Play-for-pay or workaday patients—when they come up with shoulder bursitis and your clinical judgment indicates Butazolidin alka—go with it.

And watch the comeback.



cer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Purpuric rash has also been reported. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur. 6509-V(B)R2

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Capsules

100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate
1.25 mg. homatropine methylbromide

Dosage in painful shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

For complete details, please see full prescribing information.

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many aspects of hypnosis, and enlightened the audience on the precautions which must be taken when this psychiatric tool is employed.

Dr. Rosen is associate professor of Psychiatry at The Johns Hopkins University school of medicine, and has served as visiting professor of psychiatry in 19 other medical schools throughout the country. He is the author of two books and seventy-four research articles, and has recently written another book which is scheduled for publication in the fall. Dr. Rosen is also considered one of the country's authorities on the abortion problem, and has led combined psychiatric-obstetrical ward round on the subject since 1954. He is on the Board of Directors of the Association for the Study of Abortion.

BLUE SHIELD AND THE MEDICAL ASSISTANT

The medical assistant is a valuable person in helping Blue Shield maintain effective communications with the practicing physician and his patients.

According to a survey recently released by the National Association of Blue Shield Plans, most local Plans throughout the country have established a working relationship with the medical assistants in their areas.

Contact with individual aides in doctors' offices as well as liaison with organized groups of medical assistants through local chapters of the American Association of Medical Assistants were cited by the Plans as being "extremely worthwhile."

Blue Shield Plans sponsor seminars and workshops periodically to introduce new coverages and cooperate with local *AAMA* groups in planning chapter meetings and in providing speakers to discuss various aspects of health insurance and prepayment.

In addition, a number of Blue Shield Plans indicated that they publish a variety of materials specifically for medical assistants, including manuals and newsletter, and special items in their literature for participating physicians.

The survey showed that responsibility for the Plans' liaison with physicians' aides rests largely with the professional relations or physicians relations department.

Nationally, Blue Shield has increased its liaison with medical assistants by developing articles on prepayment for local *AAMA* chapter publications and for the AAMA BULLETIN, and by exhibiting at *AAMA* conventions.

In an editorial in the June 1967 issue of The Blue Shield newspaper, *NABSP* commended the work being done by the American Association of Medical Assistants and its affiliated chapters and urged that Blue Shield "continue to expand its liaison with, and support of, the medical assistant."





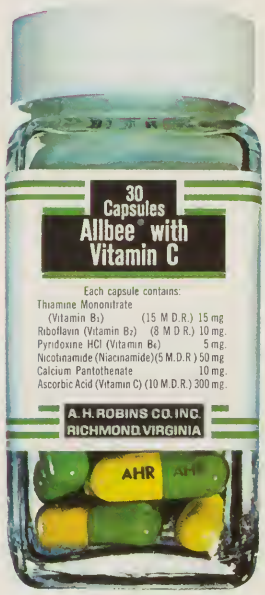
Two ways to give your patients a month's therapeutic supply of vitamin C:



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Your patient would have to eat 118 medium-sized grapefruit (almost 4 a day!) to get as much vitamin C as is provided in just one bottle of 30 Allbee with C capsules (taken one capsule daily). In addition, each capsule supplies full therapeutic amounts of the B-complex vitamins.

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hysocine hydrobromide	0.0065 mg.	0.0195 mg.
phenobarbital	(¼ gr.) 16.2 mg.	(¾ gr.) 48.6 mg.
(Warning: may be habit forming)		

Brief summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.

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Enduron is a true 24-hour single-dose thiazide. Its sodium excretion is not squeezed into an abrupt peak during the first several hours. It is well-sustained in a plateau-like effect—with little reduction for the first 12 hours, and decline thereafter only gradual.

Potassium loss, by contrast, is low. It reaches an early minor peak, then subsides rapidly. Moreover, since dosage is but once a day, there is but one daily peak of potassium loss. As with all thiazides, however, dietary potassium supplementation should also be considered, especially in long or intensive therapy.

Use Enduron as an ideal starting therapy in mild hypertension. Use it too, as a basic therapeutic building block with which other agents can be joined, for managing your more resistant hypertensives.

Once a day, every day

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DAILY DOSAGE RANGE	Minimum	Usual	Intermediate	Maximum
	2.5 mg. tablet	5 mg. tablet	7.5 mg.	10 mg.

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To build added response, shift to Enduronyl

The deserpidine component adds enhanced antihypertensive activity

The rauwolfia component of Enduronyl is deserpidine (Harmonyl®), a purified crystalline alkaloid supplied only by Abbott. It augments Enduron with its own antihypertensive and tranquilizing action.

Thus the combined clinical effect of these two therapeutic building blocks in Enduronyl is greater than can ordinarily be achieved with either alone.

To add flexibility, Enduronyl comes in two strengths: regular and Forte. Both provide 5 mg. of Enduron. The variation is where most helpful: in the deserpidine. The tablets are scored, and give a surprisingly wide and economical choice of once-a-day doses (see below).

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DAILY DOSAGE RANGE	2.5 mg. methyclothiazide 0.125 mg. deserpidine	5 mg. methyclothiazide 0.25 mg. deserpidine	7.5 mg. methyclothiazide 0.375 mg. deserpidine	10 mg. methyclothiazide 0.5 mg. deserpidine
DAILY DOSAGE RANGE	2.5 mg. methyclothiazide 0.25 mg. deserpidine	5 mg. methyclothiazide 0.5 mg. deserpidine	7.5 mg. methyclothiazide 0.75 mg. deserpidine	10 mg. methyclothiazide 1 mg. deserpidine

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Effect tied to reduced peripheral vascular resistance; no central depressant action

Eutonyl is a unique nonhydrazine agent. It is reported to act by reducing peripheral vascular resistance.[1,2]

In clinical trials, significant reductions in mean blood pressure were seen in 84% of patients studied—all were moderate to severe cases. Eutonyl lowers diastolic in proportion to systolic, and in about half of the cases studied, reductions in the sitting and recumbent positions were nearly as great as in the standing position.

Most important: There is no central depressant action. In fact, some patients reported an *increased* sense of well being.

Here, then, is a highly effective *basic treatment* for moderate to severe cases—and one that will not hamper your patient with lethargy or drowsiness while on treatment.

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PARGYLINE HYDROCHLORIDE



DAILY DOSAGE RANGE	Minimum	Usual starting	Intermediate	Maximum
	10 mg. tablet	25 mg. tablet	50 mg. tablet or as needed	200 mg.

1. Brest, A. N., et al., Cardiac and Renal Hemodynamic Response to Pargyline, Ann. N. Y. Acad. Sci., 107-1016, 1963.
2. Winsor, T., Pargyline Hydrochloride, Hypertension, Urinary Tryptamine, and Vascular Reflexes, Geriatrics, 19:598, Aug., 1964.

See Brief Summary on final page of advertisement.

Eutron adds thiazide for enhanced therapy with milder side effects

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Only a 7/4 mm. span between standing and recumbent pressures in clinical trials—reduced chance of orthostatic hypotension

The combining of Eutonyl and Enduron in Eutron permits a significantly greater antihypertensive effect than with either agent used alone. This in turn may allow therapeutic success with lesser dosage—and correspondingly milder side effects.

A significant finding in clinical trials was the drug's action in lowering blood pressure to *nearly equal levels in all body positions*. Total average spread between standing and recumbent readings (after treatment) was only 7/4 mm. Hg.

Thus, in your moderate to severe cases, Eutron affords a usually smooth course of therapy, often with reduced likelihood of orthostatic effects. (The usual precautions against rising suddenly, of course, will always apply.) And, because of the thiazide component, Eutron may be used in the presence of congestive heart failure.



Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 MG.
WITH METHYCLOTHIAZIDE 5 MG.

DAILY DOSAGE RANGE	Minimum	Usual starting	Intermediate	Maximum
	12.5 mg. pargyline hydrochloride and 2.5 mg. methyclothiazide	25 mg. pargyline hydrochloride and 5 mg. methyclothiazide	37.5 mg. pargyline hydrochloride and 7.5 mg. methyclothiazide	50 mg. pargyline hydrochloride and 10 mg. methyclothiazide

See Brief Summary on final page of advertisement.

TM—Trademark

707075-R

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Enduron is used to control edema and mild to moderate hypertension; also used with other drugs for hypertension. Enduronyl is used in mild to moderately severe hypertension; when used with Enduronyl, more potent agents can be given at reduced dosage to minimize undesirable side effects.

Contraindications: Neither Enduron nor Enduronyl should be used in severe renal disease (except nephrosis) or shutdown; in severe hepatic disease or impending hepatic coma; in patients sensitive to thiazides. Hepatic coma has been reported as a result of hypokalemia in patients receiving thiazides.

Enduronyl is contraindicated in patients with severe mental depression and suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity reactions in patients with a history of allergy or asthma. If added potassium intake is indicated, dietary supplementation is recommended. Enteric-coated potassium tablets should be reserved for cautious use only when adequate dietary supplementation is not practical because those tablets may induce serious or fatal small bowel lesions consisting of stenosis with or without ulceration. These small bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs.

Precautions: Use thiazides with caution in severe renal dysfunction, impaired hepatic function, or progressive liver disease. In surgical patients, thiazides may reduce the response to vasopressors and increase the response to tubocurarine. Use thiazides with caution in pregnancy (bone marrow depression, thrombocytopenia, or altered carbohydrate metabolism have been reported in certain newborn infants). Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. Antihypertensive response may be enhanced following sympathectomy.

Use Enduronyl with caution in patients with a history of peptic ulcer, as rauwolfias may increase gastric secretion. Discontinue at the first sign of mental depression. Rauwolfia alkaloids may increase hypotensive effects of surgery or anesthesia, and should be discontinued two weeks prior. They also lower the convulsive threshold and shorten seizure latency. In epilepsy, dosage adjustment of anticonvulsant medication may be necessary. Alcohol, barbiturates, or narcotics may potentiate action of deserpidine.

Adverse Reactions: During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). All patients should be observed for signs of hyponatremia ("low-salt" syndrome). Reported thiazide reactions include: anorexia, nausea, vomiting, diarrhea, headache, skin rash, dizziness, paresthesia, weakness, photosensitivity, jaundice, and pancreatitis.

Reported rauwolfia reactions include: nasal stuffiness, nausea, weight gain, diarrhea, aggravation of peptic ulcer, epistaxis, skin eruption, and reduction of libido and potency. Excessive drowsiness, fatigue, weakness, and nightmares may signal early signs of mental depression.

EUTONYL® | EUTRON™

PARGYLINE HYDROCHLORIDE

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications: For treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. Not recommended for patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone. It is desirable to establish the dosage of Eutron by administering component drugs separately.

TM-Trademark.

Contraindications: Pheochromocytoma, advanced renal disease, increasing renal dysfunction, paranoid schizophrenia and hyperthyroidism. Hepatic coma has been reported as consequence of hypokalemia with thiazide therapy. Until further experience is gained not recommended for patients with malignant hypertension, children under 12, or pregnant patients.

Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. 2 week interval should separate therapy and use of these agents.

Methyclothiazide is contraindicated in patients with known sensitivity to thiazides.

Warnings: Pargyline hydrochloride is a monoamine oxidase inhibitor. Warn patients against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When indicated, alcohol, narcotics (meperidine should be avoided), antihistamines, barbiturates, chloral hydrate, and other hypnotics, sedatives, tranquilizers, or caffeine, may be used cautiously in reduced dosage. In emergency surgery ¼ to ⅕ the usual dose of narcotics, analgesics, and other premedications should be used avoiding parenteral administration where possible. Carefully adjust dose of anesthetics to response of patient. Withdraw pargyline two weeks before elective surgery.

Warn patients about the possibility of postural hypotension. Those with angina or coronary artery disease should not increase physical activity with an improvement in well being. Pargyline may lower blood sugar.

Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions consisting of stenosis with or without ulceration. These small-bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs. These products contain no added potassium salts and if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical. In patients with a history of allergy or asthma the possibility of sensitivity reactions should be considered.

Precautions: Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields and fundi. Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. In surgical patients thiazides may reduce response to vasopressors and increase response to tubocurarine.

Adverse Reactions: Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extrapyramidal symptoms have been reported in a few patients with reduced cardiac reserve.

During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). Observe all patients for signs of hyponatremia ("low salt" syndrome).

Reported thiazide reactions also include anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, and pancreatitis. Nocturia has been observed with the combination.

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ABBOTT



Louis Krause, MD, Chairman
Library and History Committee

Elizabeth Sanford
Librarian

Selecting Journals for Medical Libraries

With the information explosion librarians are often puzzled regarding selection of journals for their individual libraries. A good criteria for selection is the list of journals indexed in *Index Medicus,* published since 1879 by the National Library of Medicine.

How to maintain quality as well as currency in their selection of journals has been a major problem for the National Library. In response to many suggestions, the Library decided in 1964 to base their decisions on the opinions of special subject specialists acting as a panel.

As with other organizations, the limitations of personnel and funds have controlled the number of journals which can be indexed. Initially, during the formation of the panel, the 1000 journals selected from the *List of Journals indexed in Index Medicus,* through a previous 'user' survey as the highest quality journals, were indexed in depth. The other titles were given limited indexing; that is, not over four subject headings were to be assigned to entries.

Following the recommendations of this panel, the chief of Bibliographic Services of the National Library prepared these criteria:

1. Sponsorship of the journal by a professional organization of recognized status in a given discipline or subject area.
2. Sponsorship by a national academy or national institute.
3. Existence of an active editorial board consisting of knowledgeable and critical referees with high professional standing.
4. Regular contributions to a journal by leaders in the subjects to which the journal addresses itself.
5. Strict adherence to an established format in presentation of methodology, tables, graphs, references and other data.
6. Publication policy that prohibits promotional, parochial, or secular approaches in the journal.

This information was excerpted from an article titled *Selection of Journals for Index Medicus* by Leonard Karel, PhD., National Library of Medicine in the *Bulletin of the Medical Library Association,* v.55, number 3, July 1967, p. 259-278. It is a comprehensive review of the subject and suggested reading for persons interested in one of the most specialized indexing projects in the country.

If librarians and physicians wonder why some of their pet publications do not appear on the *LJI* (List of Journals Indexed in *Index Medicus*) this article will shed some light on the methods of selection used.

New Accessions
BOOKS
(Arranged by Author-Title)

American Surgical Association Transactions, 1966. Philadelphia.

American Medical Association. Committee on the Medical Aspects of Sports. Standard nomenclature of athletic injuries. Prepared by the subcommittee on Classification of Sports Injuries, Alexius Rachum, Chairman, Chicago, *AMA* 1966.

American Medical Association. Department of Hospitals and Medical Facilities. A look at hospital construction. A review of the Hill-Burton Program and *AMA* recommendations on legislation. 1964.

American Psychiatric Association. *APA* Guidelines for psychiatric services covered under Health Insurance Plans. Washington, *APA*. 1966.

The American Social Health Association. Today's VD control problem. A joint statement by the *APHA*, the *ASHA*, the *AVDA*, the Association of State and Territorial Health Officers. American Social Health Association, 1967.

Barker, Wiley F. Peripheral arterial disease. Philadelphia, Saunders, 1966.

Bergsma, Daniel, ed. Birth defects: Conjoined twins. The National Foundation—March of Dimes, 1967.

Citizen's Commission on Graduate Medical Education. The graduate education of physicians. A report of the Citizen's Commission on Graduate Education. Chicago, *AMA* 1966.

Group for the Advancement of Psychiatry. Education for community psychiatry. New York 1967. Report No. 64.

Group for the Advancement of Psychiatry. Laws governing hospitalization of the mentally ill. New York 1966. Report No. 61.

The Johns Hopkins University. School of Hygiene and Public Health. Cerebrovascular accidents as a public health problem. Selected Recent Abstracts II. Baltimore. *JHU* 1965.

Maryland. State Department of Health. Division of Maternal and Child Health. Bureau of Preventive Medicine. Regulations for obstetrical service in hospitals of Maryland. [Baltimore] 1955.

Meltzer, Lawrence E., Pinneo, Rose, and Kitchell, J. Roderick. Intensive coronary care—a manual for nurses. Philadelphia—Presbyterian Hospital Coronary Care Unit Fund, 1965.

Memorial Hospital. Cumberland, Maryland. First annual institute on the ministry to the sick, Feb. 27, 1967.

National Conference for Professional Nurses and Physicians. The sick person needs . . . Report of the Third National Conference for Professional Nurses and Physicians, sponsored by the American Nurses Association and American Medical Association. February 23-25, 1967. Coronado, California.

National Clearing House for Mental Health information. "Red is the color of hurting." Planning for children in the hospital, based on proceedings of the workshop, Mental Health Planning for Pediatric Hospitals, held in New York, April, 1965.

National Institute of Neurological Diseases and Blindness. Eye Research. *USPHS* Publication No. 1502. 1966.

National Kidney Foundation. Renal metabolism and epidemiology of some renal diseases. Proceedings 15th Annual Conference on the kidney. New York, 1964.

National Library of Medicine. Biomedical Serials, 1950-1960. A selective list of serials in the National Library of Medicine, compiled by Lela M. Spanier. *USPHS* Publication No. 910. 1962.

National Library of Medicine. Bibliography of the History of Medicine. Bethesda, Maryland. *USPHS* Publication No. 1540.

National Library of Medicine. Bibliography on medical education for 1966. An index to the world periodical literature related to education for medicine. *USPHS*, 1966. Published as Part 2 of the Journal of Medical Education, June 1967.

National Library of Medicine. The nucleic acids. An annotated bibliography. Prepared for *NLM* under *PHS* Contract No. PH-43-63-52 with Loma Linda University 1966.

National Library of Medicine. Bibliography on smoking and health. Supplement to *PHS* Publication No. 1124.

National Library of Medicine. Directory of medical libraries outside the United States and Canada. Preliminary edition. *USPHS*. 1963. Edith D. Blair, compiler.

National Library of Medicine. Physiologic involution in normal aging man. A bibliography of literature 1956-1960. *USPHS* 1960. Dorothy Docker, compiler.

The President's Commission on Law Enforcement and Administration of Justice. Task Force report: narcotics and drug abuse. Annotations and consultant's papers. GPO 1967.

Scott, Charles E. Historical aspects in the improvement of the treatment of mental patients.

Shands, Alfred Rives, Jr. Handbook of orthopaedic surgery. 7th ed. St. Louis, C. V. Mosby Co., 1967.

US Communicable disease Center. Atlanta Tuberculosis Branch. Reported tuberculosis data—1964. Atlanta, 1966. *USPHS* Publication No. 638.

US National Center for Chronic Disease Control. National Clearing House for Smoking and Health. Directory of on-going research in smoking and health. Compiled by Herner and Company, Washington, DC. *USPHS*. 1967.

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US Public Health Service. Division of Air Pollution. No laughing matter. The cartoonist focuses on air pollution. *USPHS* Publication No. 1561. 1966.

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US Public Health Service. National Institute of Health. Division of Regional Medical Programs. Conference on Regional Medical Programs. Held at the Washington Hilton Hotel. January 15-17, 1967.

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US Public Health Service. Division of Nursing. Health manpower source book. Section 2. Washington 1966. *USPHS* Publication No. 263.

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Wunderlich, Gooloo S. Episodes and duration of hospitalization in the last year of life, US 1961. Washington, *USPHS* Publication No. 1000, ser. 22, no. 2.

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COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

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MANUAL OF PREOPERATIVE AND POST-OPERATIVE CARE, W. B. Saunder Company, Philadelphia. Editorial Subcommittee: Henry T. Randall, MD, Chairman; James D. Hardy, MD, and Francis D. Moore, MD.

The purpose of this book is to provide a useful outline for modern methods of handling the major problems of preoperative preparation and postoperative management of patients undergoing both elective and emergency surgery. It provides quick and concise access to recent advances in all phases of care that is rendered in these circumstances. Included are descriptions of the metabolic and physiologic principles that underlie successful treatment. This is a concise and well compiled book.

A SYMPOSIUM ON THE CHILD, The Johns Hopkins Press, Baltimore. Edited by John A. Askin, MD, Robert E. Cooke, MD, and J. Alex Haller, Jr., MD.

This book consists of selected essays presented on the occasion of the 75th anniversary of the Johns Hopkins Hospital and the dedication of the Children's Medical and Surgical Center, May, 1964.

The purpose of its publication is to identify important developments in the field of Pediatrics and Pediatric Surgery. It does this well and is documentary evidence of what physicians have done for the well-being of children in general.

RESPIRATORY PHYSIOLOGY by N. Balfour Slonim, MD, and John L. Chapin, PHD. The C V Mosby Company, St. Louis.

This book is a monograph on the basic physiology of respiration in which fundamental principles are stressed. Clinical applications are pointed out as the basic material is presented.

The material presented is the produce of experience in both teaching physiology and practicing medicine. While designed primarily for the medical student, it should prove useful to the physician, the physiologist and the environmental scientist.

INFANT NUTRITION by Samuel J. Fomon, MD; W. B. Saunders Company, $10.50.

This book is a compendium of current information relating to infant nutrition in technologically advanced nations. It is hoped that a greater understanding of infant nutrition by all those concerned in this field can be attained through this publication.

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BOOK REVIEWS Continued

CLINICAL NEUROSURGERY, Volumes 12 and 13, The Waverly Press, Baltimore.

These two volumes published under the aegis of John Shillito, Jr., MD, who was charged with this responsibility by the Congress of Neurological Surgeons, add to the previous volumes published by this group. Most of the latest techniques, advances and procedures are carefully delineated in these books. This compendium of the talks given at the annual Congresses should prove useful to all those interested in this highly specialized field.

CONCEPTS OF NURSING HOME ADMINISTRATION, The Macmillan Company, New York, Harold Baumgarten, Jr.

This book is the first of its kind to treat the administrator's relationships to all nursing home activities and to provide him with a comprehensive basis for making the wide range of decisions commensurate with his authority. It is a valuable text book for graduate-level and continuation courses in nursing home administration but, better than that, it is a standard reference for nursing home administrators, nursing supervisors, public health, medical care and hospital administrators. It is a book well worth having in every nursing home.

CARE OF THE TRAUMA PATIENT, McGraw-Hill Book Company, New York, G. Tom Shires, MD.

Parkland Memorial Hospital, a name that will live in the memory of many of us because of President Kennedy's assassination, is the scene of the research that resulted in the publication of this book. It is devoted to the patient and, more specifically, about the patient with single or multiple injuries. The overall attempt has been to produce a guide to the principles, pathological physiology and clinical care of the patient who is injured.

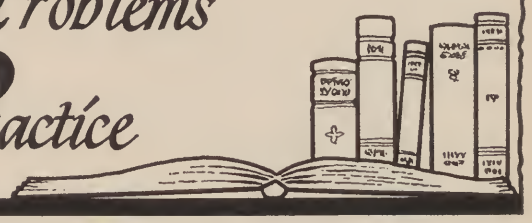
HYSTERIA AND RELATED MENTAL DISORDERS, John Wright & Sons Ltd., Bristol, England, by Wilfred Abse, MD.

The author's original book on this subject published following World War II, The Diagnosis of Hysteria, has this follow-up volume. It deals with the increasing interest in this subject. This newer publication deals more fully with problems of diagnosis and their bearing on management and treatment; and on the other hand the nature of the disturbances have been explored. The author claims that, "the adequate study of hysteria becomes a gateway to the whole field of psychological medicine." We are inclined to agree with him.

PATHOLOGY OF THE KIDNEY, Little, Brown and Company, Robert H. Heptinstall, MD.

The task of presenting a comprehensive account of the pathology of the kidney is surprisingly difficult. Accepting the imperfect state of knowledge in this area, the author has attempted to present an account of the more common diseases that affect the kidney. The book is mainly for the pathologist and the internist specializing in renal problems, but it can be of use to others such as the urologist and the obstetrician.

Solutions to Business Problems in Daily Medical Practice



How to Release an Aide

WILBURN L. McCLURE, JR.

The lazy, dishonest or incompetent aide is easy to release. You can give her a check and send her on her way.

But, what about the sincere, dedicated aide who just doesn't seem to have the ability to cope with the responsibility of her position?

When confronted with the task of releasing an aide, evaluate your motives first. Write down your grievances. Review the list carefully. Make sure your judgments are fair.

Invite your aide to sit down and go over the list with you. Review adjustments that might be made by both parties. Ask if she fully understands what you consider to be grievances. Ask if there are personal circumstances, such as family problems, ill health, or nervous tension which are having and adverse effect on the execution of her duties.

If you have considered all opportunities to make adjustments, and the situation appears irreconcilable, then by all means, *make a definite plan* toward releasing her and stick to it.

As soon as you have found what you consider to be a suitable replacement, then have a heart-to-heart talk, tactfully but firmly, with your present aide.

Explain why you feel this action is necessary. Don't just leave her hanging on a limb somewhere. It is customary to give an employee at least two weeks notice. If you intend to release her immediately, then make sure she is adquately compensated.

Once your former aide has left the office, be very careful when giving references to her new employer. One of the most serious mistakes made by doctors is to release an aide from her duties because of incompetence or dishonesty, and then give her a glowing recommendation.

One case comes to mind where a doctor released a girl who had embezzled some $3,000 from his office. He did not prosecute her, nor did he make any arrangements for her to repay the embezzled amount. He simply let her go.

A few weeks later, he received a call from a colleague who was thinking about hiring her. The doctor told him what a good worker she had been, but did not tell his colleague about the embezzlement.

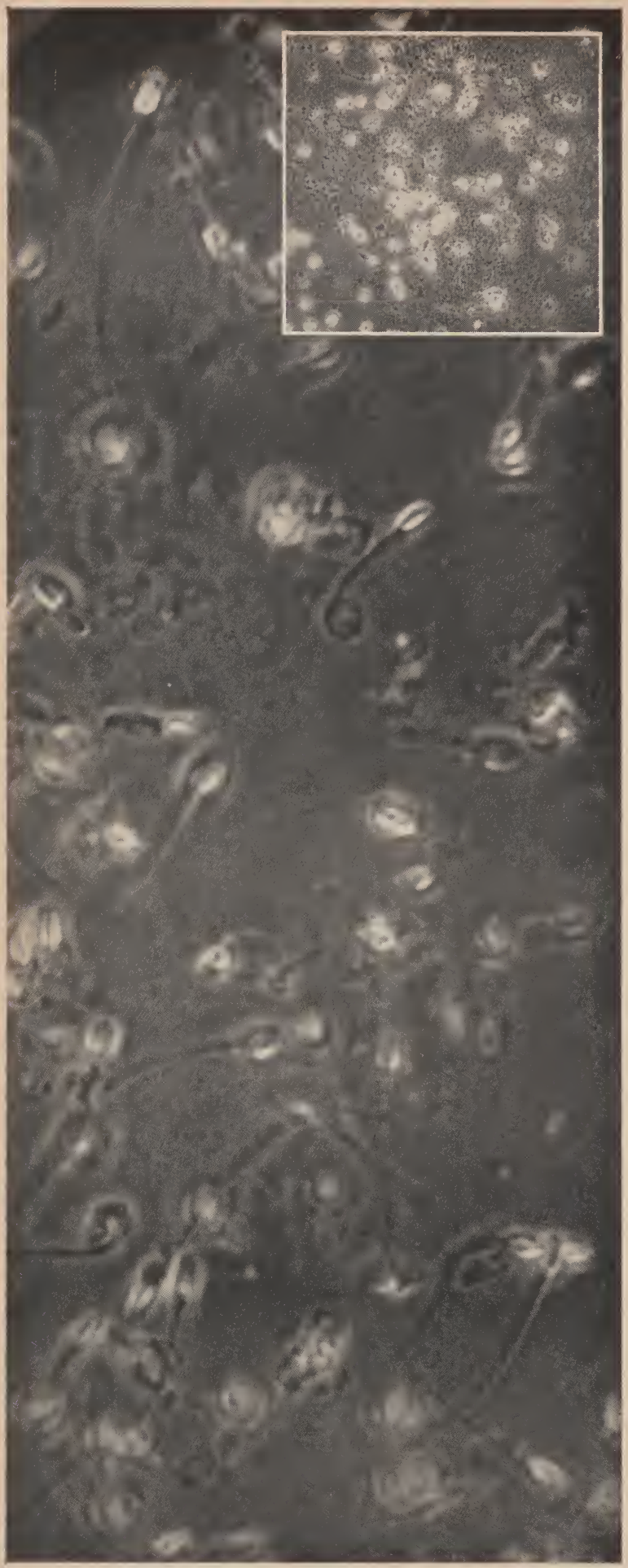
You guessed it! Some time later, his colleague called him and discussed an embezzlement in his office. This caused a considerable amount of friction between the two doctors.

If you must release an aide, it is generally the best policy to let her go prior to the arrival of your new aide. You never know what axes your former aide has to grind. Of course there is always the chance that she will pass on bad habits and unknown errors of procedures to the new girl.

Make a clean break and start fresh.

You may wish to clip this series of articles, "All About Aides" (Parts One through Five), and file for future reference.

Mr. McClure is director of the Baltimore office of Professional Business Management, Inc. This monthly column is prepared as a complimentary service to the *Maryland State Medical Journal.*



New view of an oral contraceptive at work

Although suppression of ovulation remains the primary mode of action of oral contraceptives, newer knowledge indicates that products like Norinyl-1—a combination of both low-dosage progestogen and estrogen for the full treatment cycle—may provide multiple action that helps explain their unexcelled record of contraceptive effectiveness. This report explores the possible secondary protective mechanisms offered by combined hormonal administration.

Accumulating evidence has indicated that sparse, highly viscous cervical mucus has a possible adverse effect on the motility and survival of spermatozoa.

The estrogen-opposing progestational ingredient of Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.) changes the usual mid-cycle picture of a thin, watery cervical mucus. The result—a built-in barrier that appears to inhibit sperm from reaching the ovum should one be released. The inset in the adjoining photograph shows immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

See last page for contraindications, precautions, side effects and dosage.

How the estrogen-opposing action of Norinyl-1 creates cervical mucus that may be hostile to sperm penetration

Normally, estrogen activity during the fertile midcycle stimulates the production of a profuse and watery cervical mucus that permits maximum sperm motility and promotes penetration.

But what happens when Norinyl-1 is administered? Its potent progestogen, norethindrone, opposes estrogen stimulation of cervical mucus. Consequently, the amount of mucus decreases and its viscosity increases. This results in a sparse but thick mucus barrier that appears to diminish the vitality of the sperm and to impair its powers of penetration.

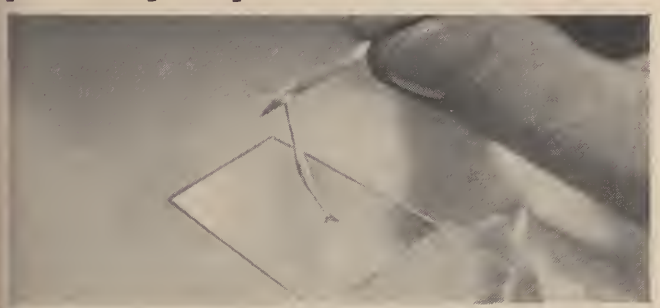
The role of viscous cervical mucus as a secondary action of Norinyl-1

In a report on 89 patients taking this medication,* cervical mucus obtained from cycle day 5 to cycle day 29 appeared scant and thick and exhibited little or no Spinnbarkeit.

In the opinion of this investigator, the effect on cervical mucus may be sufficient to prevent conception.

*Cohen, M. R.: Symposium: Mechanisms of Action of Low Dosage Oral Contraceptive, Yale University Medical Center, New Haven, Conn., April 6, 1967.

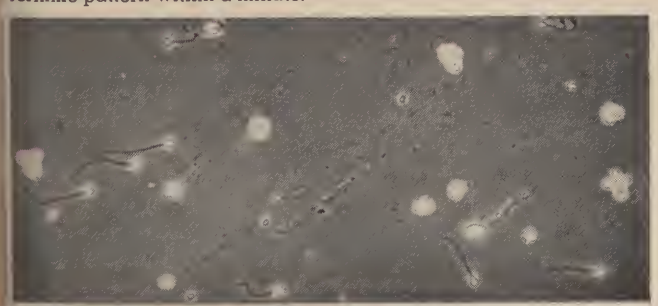
Normal cervical mucus at midcycle in untreated patient is known to permit sperm motility... promote sperm penetration.



Cervical mucus is thin and watery with a stretchability (Spinnbarkeit) of 15 to 20 cm.

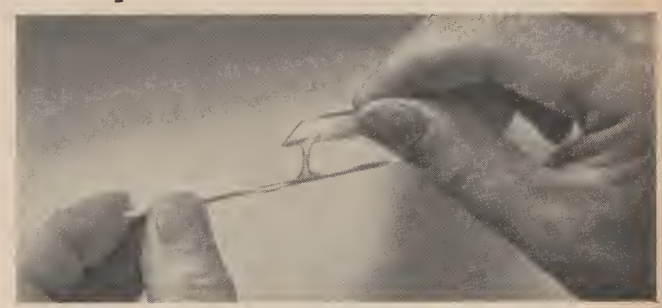


Thin, watery mucus crystallizes into this well-defined, fernlike pattern within a minute.

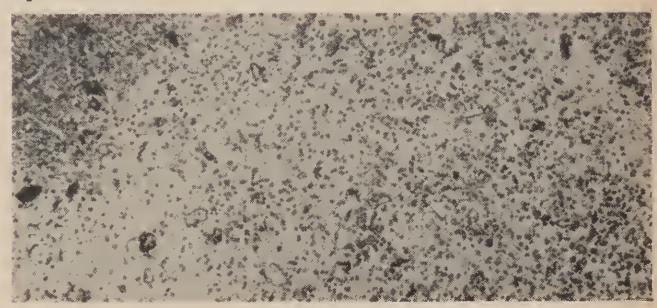


Spermatozoa appear healthy, are active and freemoving.

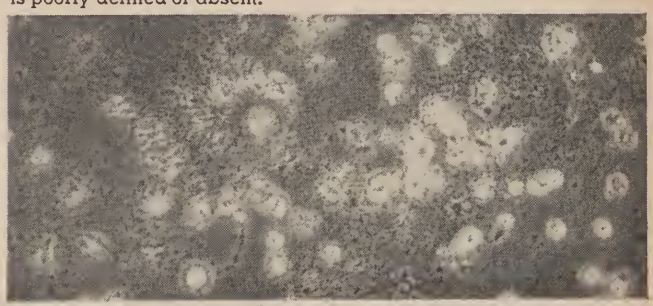
Viscous cervical mucus at midcycle produced by Norinyl-1 appears to impair sperm vitality... inhibit penetration.



Cervical mucus is scanty, thick and viscous. Spinnbarkeit is 1 cm. or less.



In thick, viscous cervical mucus the fern pattern is poorly defined or absent.



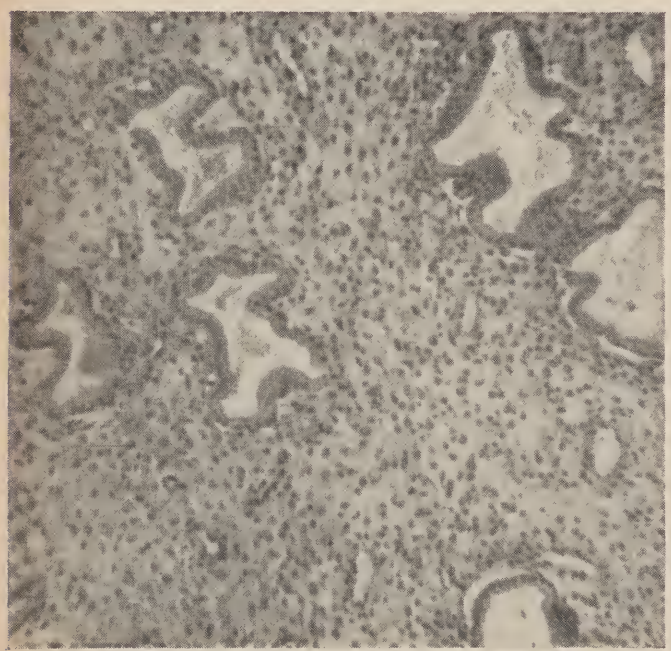
Immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

How Norinyl-1 alters normal endometrial responses—another possible protective mechanism

Let us suppose that an ovum is released—as occurs in an occasional, rare case—and somehow a sperm succeeds in penetrating the cervical mucus barrier. Should this come about, one additional action of Norinyl-1 may protect the patient from unwanted pregnancy. The theory is that progestogen intake makes endometrial tissue unreceptive to implantation.

Endometrium of untreated patient

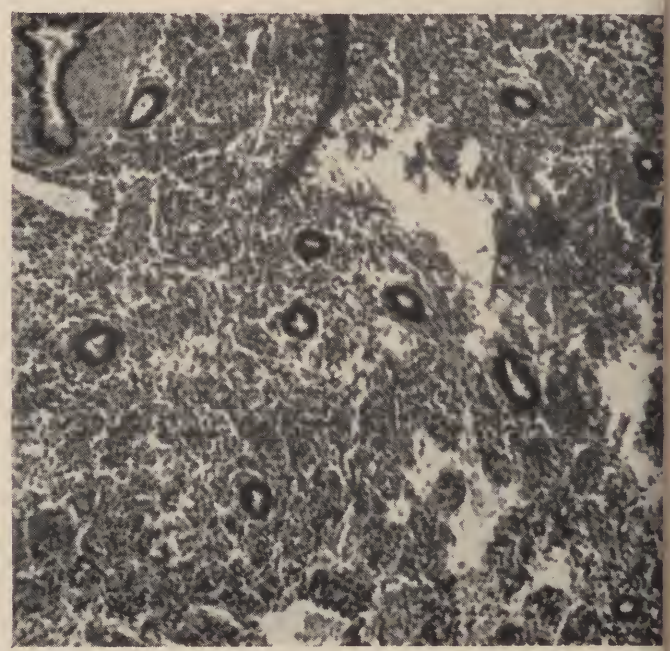




Normally, the endometrium progresses through a proliferative phase stimulated by estrogen and a secretory phase stimulated by progesterone. During the secretory phase the endometrium is receptive to the fertilized ovum.

Endometrium produced by Norinyl-1





When Norinyl-1 is administered its progestogen component—norethindrone—accelerates the secretory phase and suppresses glandular and vascular development.

See last page for contraindications, precautions, side effects and dosage.

new Norinyl-1® tablets

(norethindrone 1mg. & mestranol 0.05mg.)

for multiple contraceptive action

effective fertility control on half the previous dosage

maintains ratio of the established norethindrone/mestranol combination

lower cost

new Norinyl®-1

(norethindrone 1mg. c̄ mestranol 0.05mg.) **tablets**

Reduction of oral contraceptive dosage to lowest effective levels has become a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now available in a new strength in which *both* norethindrone and mestranol are reduced 50 percent. Studies show that Norinyl-1 achieves fertility control with only 1.05 mg. of combined progestogen and estrogen per tablet.

Norethindrone was first reported for use as a progestational agent in human beings in 1955. Norethindrone 2 mg. with mestranol 0.1 mg., as an oral contraceptive, is currently in use by over 2,000,000 women. Clinical experience now establishes that Norinyl-1 also amply meets the criteria of reliability and safety.*

*Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965.

PRESCRIBING INFORMATION

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of Norinyl-1 in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with Norinyl-1. Therefore, if such tests are abnormal in a patient taking Norinyl-1, it is recommended that they be repeated after the drug has been withdrawn for 2 months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibroids may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac, or renal dysfunction, require careful observation. 5. Although a cause and effect relationship has not been established, Norinyl-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, as in all cases of irregular bleeding per *vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged Norinyl-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Norinyl-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. A cause and effect relationship has not been demonstrated. 11. Because of the effects of estrogens on epiphyseal closure, Norinyl-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask the onset of the climacteric. 13. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma, breast changes (tenderness, enlargement and secretion), loss of scalp hair, change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, erythema multiforme, erythema nodosum, hemorrhagic eruption, migraine, rash (allergic), itching, rise in blood pressure in susceptible individuals, mental depression.

The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has not been established: thrombophlebitis, pulmonary embolism, neurooocular lesions.

The following laboratory results may be altered by the use of oral contraceptives: increased bromsulphalein retention and other hepatic function tests, coagulation tests (increase in prothrombin, factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metapyrone test, pregnanediol determination.

Other side effects reported to have occurred in association with use of this drug are dizziness, hirsutism, pains in legs, back, chest and abdomen, dysuria, drowsiness, vaginal discharge, libido increased and decreased, eruptions, hypermenorrhea, hypomenorrhea, increased appetite, G.U. infections, varicose veins, abdominal fullness, acne, headache, nervousness, allergies, blurred vision, pain in eyes, and itching in eyes. *For complete clinical data, see package insert.*

Dosage and Administration: 1. One tablet of Norinyl-1 is administered orally for 20 days beginning on day 5 of the menstrual cycle. (Count day 1 of the cycle as the first day of menstrual bleeding.) Repeat this dosage schedule for each cycle. 2. If no menstrual period occurs after a cycle of treatment (20 tablets) in which patient adhered to the schedule, the patient must be instructed to resume taking the Norinyl-1 tablets 7 days after the previous 20-day course was completed. For example, if the last pill of a previous cycle had been taken on a Sunday, then a new cycle of treatment should begin on the following Sunday. 3. In the postpartum woman, it is recommended that the first cycle of treatment should begin on day 5 of the first menstrual cycle. However, Norinyl-1 should not be administered during lactation.

Availability: Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.)—Dispensers of 20 and 60 and bottles of 250 tablets.

norethindrone — an original steroid from

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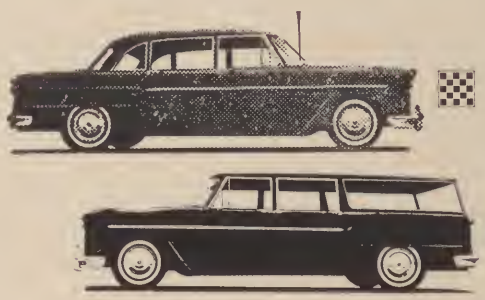
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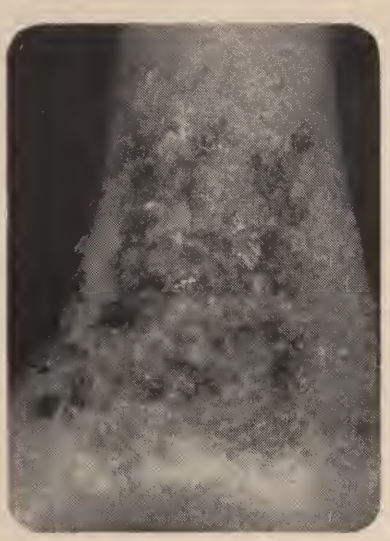
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ARISTOCORT® Triamcinolone Acetonide Topicals have proved exceptionally effective in the control of various forms of eczema: allergic, atopic, nummular, psoriatic, and mycotic.

In most cases responsive to topical ARISTOCORT, the 0.1% concentration is sufficiently potent. The 0.5% concentration provides enhanced topical activity for patients requiring additional potency for proper relief.

Administration and Dosage: Apply sparingly to the affected area 3 or 4 times daily. Some cases of psoriasis may be more effectively treated if the 0.1% Cream or Ointment is applied under an occlusive dressing.

Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

Available in 5 Gm. and 15 Gm. tubes and ½ lb. jars.

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406-6

BALTIMORE CITY MEDICAL SOCIETY

1211 Cathedral Street, Baltimore, Maryland 21201

JOINT MEETING WITH THE BALTIMORE CITY DENTAL SOCIETY
FRIDAY, OCTOBER 6, 1967, 8:30 P.M.

HEALTH MANPOWER DEVELOPMENT IN OUR NATION

LEONARD D. FENNINGER, M.D., Director, Bureau of Health Manpower, Department of Health Education and Welfare

***

QUESTION AND ANSWER PERIOD

*

Acceptable for 2 hours Category I Credit by the American Academy of General Practice

*

Members of the Maryland Nurses Association have been invited to be our guest at this meeting.

SECTION ON INTERNAL MEDICINE

Lester Wall, Jr., MD, President
J. Rollin Otto, Jr., MD, Secretary

Joint Meeting With The Maryland Society of Internal Medicine
Monday, October 2, 1967, 8:15 p.m.

WHO SAYS IT IS REASONABLE? Richard S. Wilbur, MD, Chairman, Board of California Blue Shield, Palo Alto, California.

CURRENT LABOR VIEWPOINTS TOWARD HEALTH INSURANCE. Jerome Chamovitz, MD, Member *ASIM* Committee on Labor and Management, Pittsburgh, Pa.

WOMAN'S AUXILIARY TO THE BALTIMORE CITY MEDICAL SOCIETY

Mrs. Max R. English, President
Mrs. John W. Ashworth, Secretary
Mrs. S. G. Sullivan, Treasurer

Wednesday, October 11, 1967
Luncheon Meeting, 12:00 o'clock

THE EFFECTIVE USE OF MILITARY AND MEDICAL RESOURCES IN INTERNATIONAL COOPERATION. Colonel William C. Holmberg, US Marine Corps.

MARYLAND PSYCHIATRIC SOCIETY

Francis McLaughlin, MD, President
Eugene Brody, MD, Secretary
Thursday, October 12, 1967, 8:30 p.m.

IDENTITY PROBLEMS OF AMERICAN NEGRO ADOLESCENTS. Chester M. Pierce, MD, Associate Professor of Psychiatry, University of Oklahoma School of Medicine, Oklahoma City, Okla.

PATHOLOGY SECTION

Edward L. Sherrer, MD, Chairman
William J. Hicken, MD, Secretary
Monday, October 16, 1967, 8:00 p.m.

Program to be announced.

MARYLAND RADIOLOGICAL SOCIETY

William Wallop, MD, President
Henry H. Startzman, MD, Secretary
Tuesday, October 17, 1967
Meeting 7:00 p.m., The Johns Hopkins Hospital
Dinner 8:00 p.m., Sheraton-Baltimore Inn

Speaker to be announced.

SECTION ON REHABILITATION

Julian Reed, MD, Chairman
J. Michael Coyne, MD, Secretary
Wednesday, October 18, 1967, 8:00 p.m.

BETTER TREATMENT FOR THE ARTHRITIC: RHEUMATOLOGIST AND PHYSIATRIST SHOULD WORK TOGETHER. Marjorie H. Hendry, MD, Physiatrist; K. A. Peter van Berkum, MD, Rheumatologist.

ANESTHESIA STUDY COMMITTEE

Joint Anesthesia Study Committee of the Baltimore City Medical Society and the Baltimore City Health Department.

Tuesday, October 24, 1967, 7:30 p.m.

COMING MEETINGS
NOVEMBER 1967
BALTIMORE CITY MEDICAL SOCIETY

Friday, November 3, 1967, 8:30 p.m.

MEDICAL LEGISLATION AND THE MEDICAL PROFESSION. The Hon. Charles McC. Mathias, Jr., Congress of The United States.

MARYLAND PEDIATRIC SOCIETY

Tuesday, November 14, 1967, 8:30 p.m.
Business Meeting

BALTIMORE CITY HEALTH DEPARTMENT

ROBERT E. FARBER, M.D., M.P.H.
COMMISSIONER

American Building, Baltimore and South Streets
Baltimare, Maryland 21202

752-2000: Extension 307

Learn To Do Your Part In The Prevention Of Disease

Computer System for Tuberculosis Cases

A computerized tuberculosis case register system has been established in the Baltimore City Health Department as part of a national computer system sponsored by the US Public Health Service for recording information essential to the measurement and control of tuberculosis.

Baltimore is the first large city in the US to be selected by the Public Health Service to demonstrate the value of this technique in the control of tuberculosis. The city was so chosen because of its tuberculosis problem and its suitability for the trial due to the constructive progress that has been made here in recent years in tuberculosis control.

Information concerning tuberculosis patients will be recorded on suitable forms in the chest clinics at the five health district offices and forwarded monthly to the US Public Health Service for processing. Summary data will be quickly returned which will clearly indicate the status of every tuberculosis patient in the city and bring to attention those who are not under current medical supervision, receiving adequate treatment, or who are otherwise in need of prompt public health services.

The discovery of new drugs which are specific for, and effective in the treatment of tuberculosis have replaced the "rest cure." With adequate drug treatment, most patients are promptly rendered non-infectious, thus reducing long hospital stay and the associated high cost to the taxpayer for hospital care. Patients are thus returned safely to their homes earlier and can be cared for adequately and much more economically by their private physicans or at the city's chest clinics. Important strides, therefore, are being made in the extension and improvement of the Health Department's chest clinics to meet this increasing need.

The computer system is expected to prove a most valuable tool in keeping track of the ambulant patient and in assuring his long continued regular use of the drugs which will assure his return to good health.

The City Health Department's Tuberculosis Control Program is under the direction of James E. Peterman, MD, Director of the Bureau of Communicable Diseases, Allan S. Moodie, MD, Administrative Health Officer for Tuberculosis, and Meyer W. Jacobson, MD, Director of Chest Clinics.

Robert E. Farber, M.D.
Commissioner of Health

MEDIC

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FRIDAY PROGRAMS

APPROPRIATE CREDIT WILL BE GIVEN BY THE AMERICAN ACADEMY OF GENERAL PRACTICE FOR ATTENDANCE.

SEPTEMBER 22—1:00 P.M.

Digitalis

Lawrence S. Cohen, MD, National Heart Institute, National Institutes of Health

Sponsor: Frederick Memorial Hospital

SEPTEMBER 29—12:30 P.M.

Current Concepts in the Management of Hodgkins Disease

Paul P. Carbone, MD, National Cancer Institute, National Institutes of Health

Sponsor: Cumberland Memorial Hospital

OCTOBER 6—12:30 P.M.

Emergency Room—Quality Care

Julius R. Krevans, MD, Physician in Chief, Baltimore City Hospitals
Joseph R. Bianchine, MD, Instructor of Medicine, The Johns Hopkins University School of Medicine
Sidney Kreider, MD, Assistant Resident, Baltimore City Hospitals

Sponsor: Baltimore City Hospitals

OCTOBER 13—12:30 P.M.

Diagnostic Problems Panel Discussion

Moderator: Thaddeus E. Prout, MD, Chief of Medicine, Greater Baltimore Medical Center

Sponsor: Greater Baltimore Medical Center

OCTOBER 20—12:30 P.M.

Management of Multiple Severe Injuries Panel Discussion

Moderator: John C. Stauffer, MD, Internist, Hagerstown

Sponsor: Washington County Hospital

OCTOBER 27—1:00 P.M.

Prognostic Assessment of the Cardiac Patient in Need of Surgery

J. O'Neal Humphries, MD, Assistant Professor of Medicine, The Johns Hopkins University School of Medicine

Sponsor: Frederick Memorial Hospital

NOVEMBER 3—12:30 P.M.

Emotional Disturbances in the Aged
Panel Discussion

Moderator: Myron F. Eichler, MD, Research Assistant Professor, Department of Psychiatry, University of Maryland School of Medicine

Sponsor: Maryland Psychiatric Society

NOVEMBER 10—12:30 P.M.

Beta Adrenergic Blockade Agents

Bernard Tabatznik, MD, Chief Cardiologist, Sinai Hospital of Baltimore, Inc.

Sponsor: Sinai Hospital of Baltimore, Inc.

NOVEMBER 17—12:30 P.M.

Poisoning and Poison Control

Gina M. Glick, MD, Poison Control Officer, Sacred Heart Hospital
Elizabeth G. Brings, MD, Pediatrician, Cumberland

Sponsor: Sacred Heart Hospital

NOVEMBER 24—1:00 P.M.

Cardiac Failure in Infancy and Childhood

Catherine A. Neill, MD, Associate Professor of Pediatrics, The Johns Hopkins University School of Medicine

Sponsor: Frederick Memorial Hospital

DECEMBER 1—12:30 P.M.

Coronary Care Unit—Purpose and Management

Kenneth B. Lewis, MD, Chief of Cardiovascular Division, Baltimore City Hospitals

Sponsor: Baltimore City Hospitals

DECEMBER 8—12:30 P.M.

Diagnostic Problem
Panel Discussion

Moderator: Thaddeus E. Prout, MD, Chief of Medicine, Greater Baltimore Medical Center

Sponsor: Greater Baltimore Medical Center

DECEMBER 15—12:30 P.M.

Unmasking Malignancies of the Ear, Nose, and Throat

Jerrie Cherry, MD, Assistant Professor of Surgery, Laryngology, and Otolaryngology, The Johns Hopkins University School of Medicine

Sponsor: Cumberland Memorial Hospital

JANUARY 5—12:30 P.M.

Management of Epileptics

Jerome K. Merlis, MD, Professor of Neurology and Clinical Neurophysiology, University of Maryland School of Medicine

Sponsor: Maryland General Hospital

JANUARY 12—12:30 P.M.

Current Problems in the Prevention of Rheumatic Fever

Milton Markowitz, MD, Associate Professor of Pediatrics, The Johns Hopkins University School of Medicine

Sponsor: Sinai Hospital of Baltimore, Inc.

JANUARY 19—12:30 P.M.

Treatment of Acute Eye Injuries

Ralph E. Longway, MD, Chief of Ophthalmology, Washington Sanitarium and Hospital

Sponsor: Eugene Leland Memorial Hospital

JANUARY 26—1:00 P.M.

Neurosurgical Aspects of Strokes

Perry Black, MD, Instructor of Neurosurgery, The Johns Hopkins University School of Medicine

Sponsor: Frederick Memorial Hospital

FEBRUARY 2—12:30 P.M.

Burn Unit—Concepts of Burn Therapy

Thomas J. Krizek, MD, Chief, Division of Plastic Surgery, Baltimore City Hospitals

Sponsor: Baltimore City Hospitals

FEBRUARY 9—12:30 P.M.

Diagnostic Problems
Panel Discussion

Moderator: Thaddeus E. Prout, MD, Chief of Medicine, Greater Baltimore Medical Center

Sponsor: Greater Baltimore Medical Center

FEBRUARY 16—12:30 P.M.

The Use of the Umbilical Vein in Diagnosis and Research of Problems of Portal Hypertension

John H. E. Bayley, MD, Chief of Surgery, Prince George's General Hospital

Sponsor: Prince George's General Hospital

FEBRUARY 23—1:00 P.M.

Pulmonary Embolism

Gottlieb C. Friesinger, MD, Assistant Professor of Medicine, The Johns Hopkins University School of Medicine

Sponsor: Frederick Memorial Hospital

MARCH 1—12:30 P.M.

Uses of Dextran

C. Thomas Flotte, MD, Associate Professor of Surgery, University of Maryland School of Medicine

Sponsor: Maryland General Hospital

MARCH 8—12:30 P.M.

Making the Double Diagnosis: Or a New Look at History Taking

Ephraim T. Lisansky, MD, Associate Professor of Medicine and Psychiatry, University of Maryland School of Medicine

Sponsor: Sinai Hospital of Baltimore, Inc.

MARCH 15—12:30 P.M.

Diagnosis and Therapy of Hyperlipemic States

Simeon Margolis, MD, Assistant Professor of Medicine, The Johns Hopkins University School of Medicine

Sponsor: Anne Arundel General Hospital

MARCH 22—1:00 P.M.

Bacterial Endocarditis

Philip A. Tumulty, MD, Professor of Medicine, The Johns Hopkins University School of Medicine

Sponsor: Frederick Memorial Hospital

MARCH 29—12:30 P.M.

Cobalt Therapy in a Community Hospital

Albert P. Marsh, MD, Chief of Radiology, Sacred Heart Hospital
William R. Newman, MD, Radiologist, Sacred Heart Hospital

Sponsor: Sacred Heart Hospital

APRIL 5—12:30 P.M.
Diagnosis and Therapy of Gout

L. Myrton Gaines, Jr., MD, Instructor of Medicine, The Johns Hopkins University School of Medicine

Sponsor: The Arthritis and Rheumatism Foundation of Maryland

APRIL 12—12:30 P.M.

Chronic Intermittent Hemodialysis in a Community Hospital

William G. Esmond, MD, Associate in Medicine, Assistant Professor in Surgery, University of Maryland School of Medicine

Sponsor: St. Joseph Hospital

APRIL 19

No Medic Lecture

170th Annual Meeting
Medical and Chirurgical Faculty of the State of Maryland
Baltimore

APRIL 26—1:00 P.M.

Catecholamines

Karl Engleman, MD, Senior Investigator, Experimental Therapeutics, Branch, National Heart Institute, National Institutes of Health

Sponsor: Frederick Memorial Hospital

MAY 3—12:30 P.M.

Cor Pulmonale

Donald H. Dembo, MD, Chief of Cardiology, Maryland General Hospital

Sponsor: Maryland General Hospital

MAY 10—12:30 P.M.

Poisonous Bites

Emily Seydel, MD, Poison Control Center, Baltimore City Hospitals

Sponsor: Baltimore City Hospitals

MAY 17—12:30 P.M.

Oral Therapy in Diabetes

Abraham A. Silver, MD, Chief of Medicine and Metabolism, North Charles General Hospital
Sponsor: North Charles General Hospital

MAY 24—1:00 P.M.

Arteriosclerosis

Benjamin M. Baker, Jr., MD, Professor of Medicine, The Johns Hopkins University School of Medicine
Sponsor: Frederick Memorial Hospital

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CONTINUING PROGRAMS

(Heard at participating hospitals only)

TUESDAY MORNINGS—11:30 A.M.

MEDICAL GRAND ROUNDS
University of Maryland Hospital

FRIDAY AFTERNOON—2:00 P.M.

NEUROLOGY GRAND ROUNDS
University of Maryland Hospital

SATURDAY MORNINGS—8:00 A.M.

PEDIATRIC GRAND ROUNDS
The Johns Hopkins Hospital

SATURDAY MORNINGS—10:00 A.M.

MEDICAL GRAND ROUNDS
The Johns Hopkins Hospital

SPECIAL INTEREST PROGRAMS

Joint Anesthesia Study Committee of the Baltimore City Medical Society and the Baltimore City Health Department

Presentation of Cases
7:30 p.m.

September 26	February 27
October 24	March 26
November 28	April 23
January 23	May 28

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Participating hospitals:

Anne Arundel General, Annapolis
Baltimore City, Baltimore
Baltimore County General, Randallstown
Calvert County, Prince Frederick
Cambridge-Maryland, Cambridge
Carroll County General, Westminster
Church Home, Baltimore
Cumberland Memorial, Cumberland
Easton Memorial, Easton
Eugene Leland Memorial, Riverdale
Frederick Memorial, Frederick
Greater Baltimore Medical Center, Towson
Harford Memorial, Havre de Grace
The Johns Hopkins, Baltimore
Kent & Queen Anne's, Chestertown
Lutheran, Baltimore
Maryland General, Baltimore
Montgomery General, Olney
North Charles General, Baltimore
Peninsula General, Salisbury
Prince George's General, Cheverly
Provident, Baltimore
Sacred Heart, Cambridge
St. Josephs, Baltimore
St. Mary's, Leonardtown
Sinai, Baltimore
Union Hospital of Cecil County, Elkton
Union Memorial, Baltimore
University of Maryland, Baltimore
Washington County, Hagerstown

Other locations:

Medical and Chirurgical Faculty, Baltimore
State Office Building, Baltimore
Hospital Council of Maryland, Inc., Baltimore

For further information contact:

Medical and Chirurgical Faculty of the State of Maryland
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539-0872
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What's all the fuss about bactericidal?

The ultimate aim in antibiotic therapy is to contain the bacterial colony and eliminate infection. Both 'cidal' agents and bacteriostatic DECLOMYCIN achieve this goal. DECLOMYCIN inhibits susceptible pathogens by stopping their growth; cidal agents affect the pathogens only while they are growing.

Though the two mechanisms differ, the end result is the same—containment of the infecting organism. *However, a very important attribute of any antibiotic is its potency against a broad range of pathogens.* DECLOMYCIN not only offers broad-spectrum potency, but high serum and tissue levels with persistent activity against tetracycline-sensitive organisms. Therapeutic benefits continue for 1-2 days after dosage stops to help prevent relapsing infection.

These are the reasons why so many doctors make DECLOMYCIN their basic broad-spectrum antibiotic. At last count, one billion doses had been administered since its introduction, and the number keeps rapidly growing.

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DEMETHYLCHLORTETRACYCLINE

Lederle

Prescribing information on next page.

For a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill.

True broad spectrum

DECLOMYCIN Demethylchlortetracycline should be equally or more effective than other tetracyclines when the offending organisms are tetracycline-sensitive.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes. A rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth — dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Capsules: 150 mg; **Tablets:** film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

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Tuinal helps wakeful patients fall asleep fast, stay asleep all night.

Indications: Tuinal is indicated for prompt and moderately long-acting hypnosis. It is not suitable for continuous daytime sedation.

Contraindications: Barbiturates should not be administered to anyone with a history of porphyria, nor should they be given in the presence of uncontrolled pain, because excitement may result.

Warning: May be habit-forming.

Precautions: Tuinal should be used cautiously in patients with decreased liver function, since prolongation of effect may occur.

Adverse Reactions: Idiosyncrasy, such as excitement, hangover, or pain, may appear. Hypersensitivity reactions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.

Overdosage: C.N.S. depression. Symptoms—Depression of respiration and of superficial and deep reflexes, slight constriction of the pupils (in severe poisoning, dilation), decreased urine formation, lowered body temperature, coma. Treatment—Symptomatic and supportive (gastric lavage; intravenous fluids; maintenance of blood pressure, body temperature, and adequate respiration). Dialysis may speed removal of barbiturates from body fluids.



Dosage: 50-200 mg. (¾-3 grains) at bedtime.

[031767]

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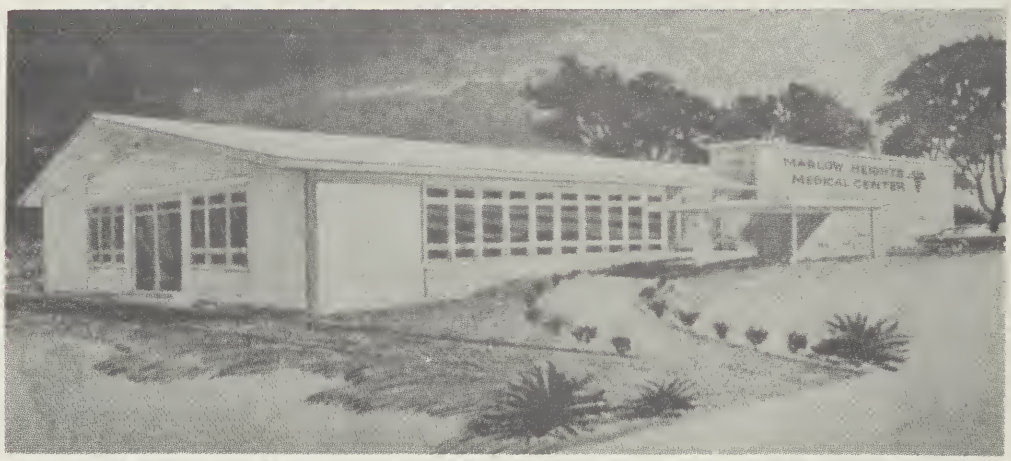
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Recently Modell[2] has stated: "The mercurial diuretics are the injectable diuretics of choice since they are the most potent as well as the most dependable. Their toxicity is not an important consideration either by comparison with other potent diuretics or in relation to the seriousness of the conditions in which they provide such excellent relief."

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IN BRIEF

Mercuhydrin is indicated in edema of cardiac or hepatic origin and in the nephrotic syndrome; it is contraindicated in acute nephritis and in anuric or oliguric states. *The usual adult dose is one to two cc. daily or every other day until "dry weight" is obtained.* Sensitivity is rare but small initial doses are advised to minimize potential reactions; vertigo, fever, and rash have occurred. Overdosage may produce electrolyte depletion, muscle cramps, and G. I. reactions. Supplied: 1 cc. and 2 cc. ampuls in boxes of 12, 25 and 100; 10 cc. rubber capped, multiple-dose vials (intramuscular or subcutaneous use only) in boxes of 6 and 100.

1. Gold, Harry, *et al.: A System for the Routine Treatment of the Failing Heart,* The American Journal of Medicine, Vol. III, No. 6:665-692 (Dec.) 1956.

2. Modell, Walter: *Drugs of Choice 1966-1967,* p. 97, 1966.

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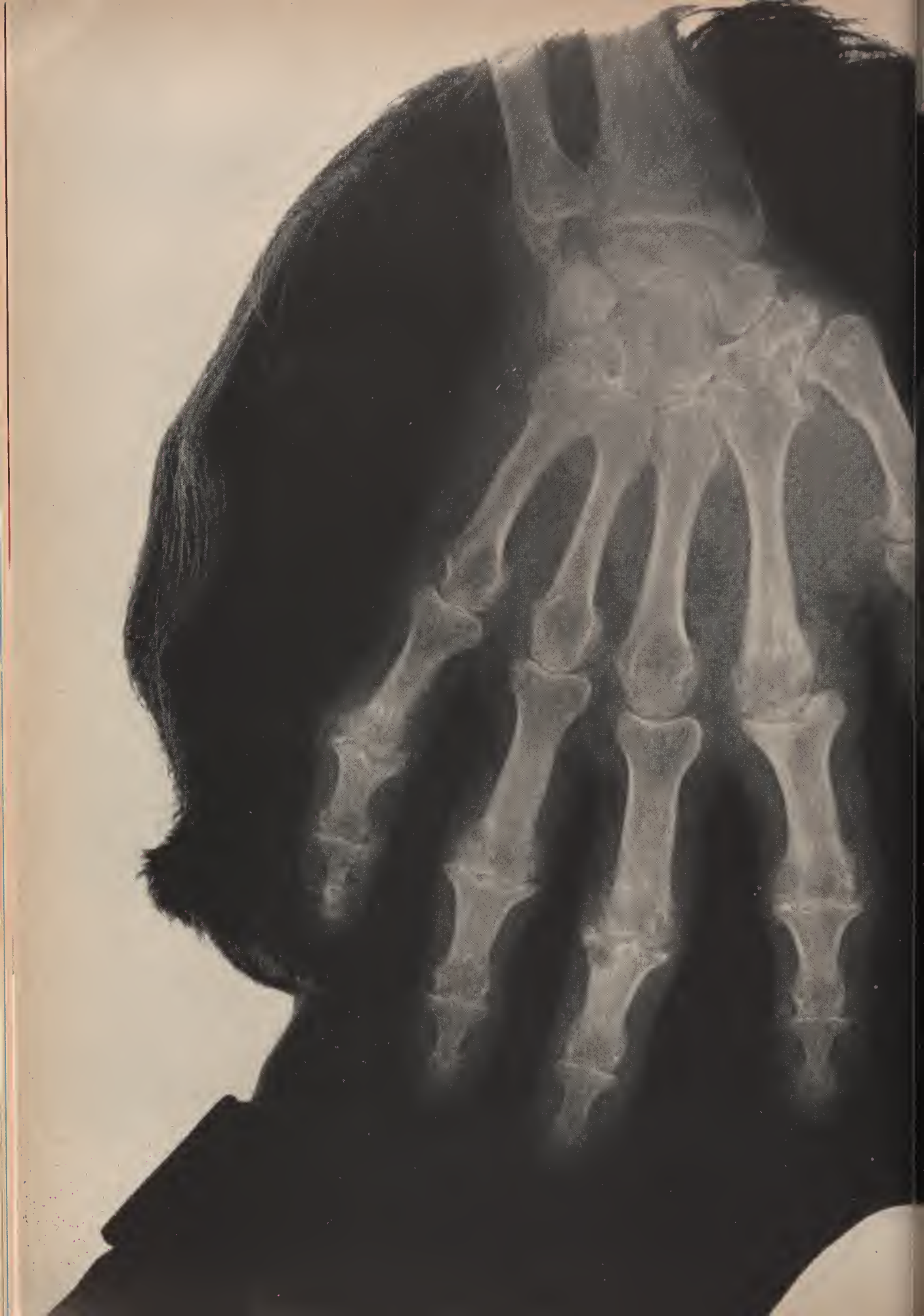
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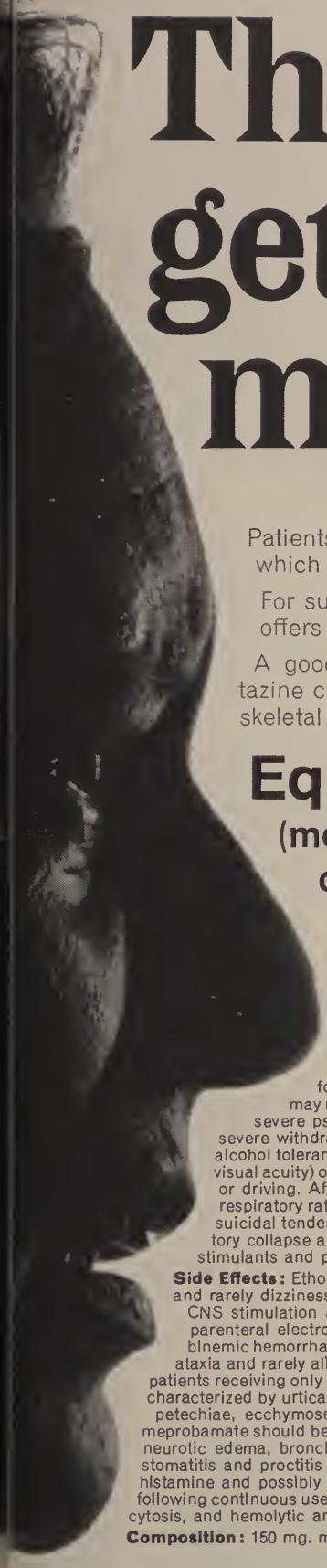
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Contraindications: History of sensitivity or severe intolerance to aspirin or meprobamate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate may result in dependence or habituation in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics. Withdraw gradually after prolonged high dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, caution patients against operating machinery or driving. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with immediate gastric lavage and appropriate supportive therapy (CNS stimulants and pressor amines as indicated).

Side Effects: Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness. Overdosage may result in CNS depression (drowsiness and lightheadedness) or CNS stimulation and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]). Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically such as with epinephrine, antihistamine and possibly hydrocortisone. A few cases of leucopenia, usually transient, have been reported following continuous use. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

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By helping overcome anxiety and tension which can thwart the convalescent's progress, EQUANIL (meprobamate) often may play an important role in medical and surgical aftercare.

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Contraindications: History of sensitivity to meprobamate.

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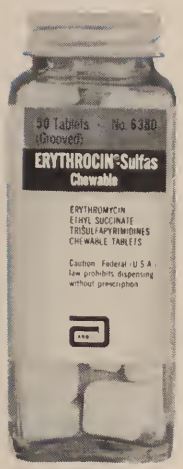
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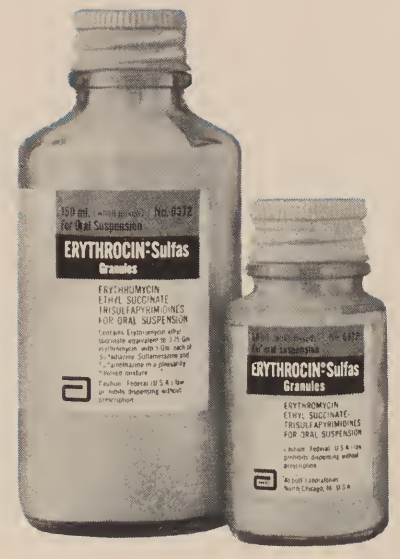
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87 patients were treated[1,2]—all children, ages four months to 15 years.

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53 were clinically cured within 72 hours, while 32 showed partial relief within the same time, and subsequent clinical cure.

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A clinical cure rate of 97.7%

1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

ABBOTT

Brief Summary on next page

PROFESSIONAL COURTESY

The custom of professional courtesy embodies the ancient tradition of fraternalism among physicians in the art which they share, and their mutual concern to apply their learning for the benefit of one another as well as their patients. The Judicial Council reaffirms and endorses the principle of professional courtesy as a noble tradition that is adaptable to the changing scene of medical practice.

Professional courtesy is not a rule of conduct that is to be enforced under threat of penalty of any kind. It is the individual responsibility of the physician to determine for himself and within his own conscience to whom and the extent to which he shall allow a discount from his usual and customary fees for the professional services he renders, and to whom he shall render such services without charge as professional courtesy.

The following guidelines are offered as suggestions to aid physicians in resolving questions related to professional courtesy.

1. Where professional courtesy is offered by a physician but the recipient of services insists upon payment, the physican need not be embarrassed to accept a fee for his services.

2. Professional courtesy is a tradition that applies solely to the relationship that exists among physicians. If a physician or his dependents have insurance providing benefits for medical or surgical care, a physician who renders such service may accept the insurance benefits without violating the traditional ethical practice of physicians caring for the medical needs of colleagues and their dependents without charge.

3. In the situation where a physician is called upon to render services to other physicians or their immediate families with such frequency as to involve a significant proportion of his professional time, or in cases of long-term extended treatment, fees may be charged on an adjusted basis so as not to impose an unreasonable burden upon the physician rendering services.

4. Professional courtesy should always be extended without qualification to the physician in financial hardship, and members of his immediate family who are dependent upon him.

Adopted by Judicial Council of AMA June 17, 1967.

ERYTHROCIN®-SULFAS
Brief Summary

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or newborn infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. of each of sulfadiazine, sulfamerazine and sulfamethazine.

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IN BRIEF:

INDICATIONS: In depression of any kind —neurotic and psychotic depressive reactions; manic-depressive or involutional psychotic reactions.

CONTRAINDICATIONS: Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease, epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor.

RELATIVE CONTRAINDICATIONS: (1) Patients with a history of paroxysmal tachycardia. (2) Patients receiving concomitant therapy with thyroid, anticholinergics or sympathomimetics may experience potentiation of effects of these drugs. (3) Safety in pregnancy has not been established.

PRECAUTIONS: (1) Outpatient use of desipramine hydrochloride should not be substituted for hospitalization when risk of suicide or homicide is considered grave. (2) If serious adverse effects occur, reduce dosage or alter treatment. (3) In patients with manic-depressive illness a hypomanic state may be induced. (4) Discontinue drug as soon as possible prior to elective surgery.

ADVERSE EFFECTS: Side effects, usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, anxiety, agitation and stimulation, insomnia, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, tremor, allergy, agranulocytosis, altered liver function, ataxia, and extrapyramidal signs.

DOSAGE: Optimal results are obtained at a dosage of 50 mg., t.i.d. (150 mg./day). **SUPPLIED:** NORPRAMIN (desipramine hydrochloride) tablets of 25 mg.; bottles of 50, 500 and 1000; and tablets of 50 mg., in bottles of 30, 250 and 1000.

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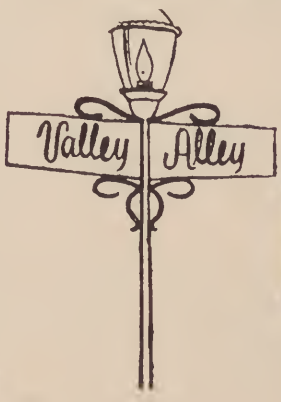
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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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Vol. 16, No. 10
October, 1967

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Maryland
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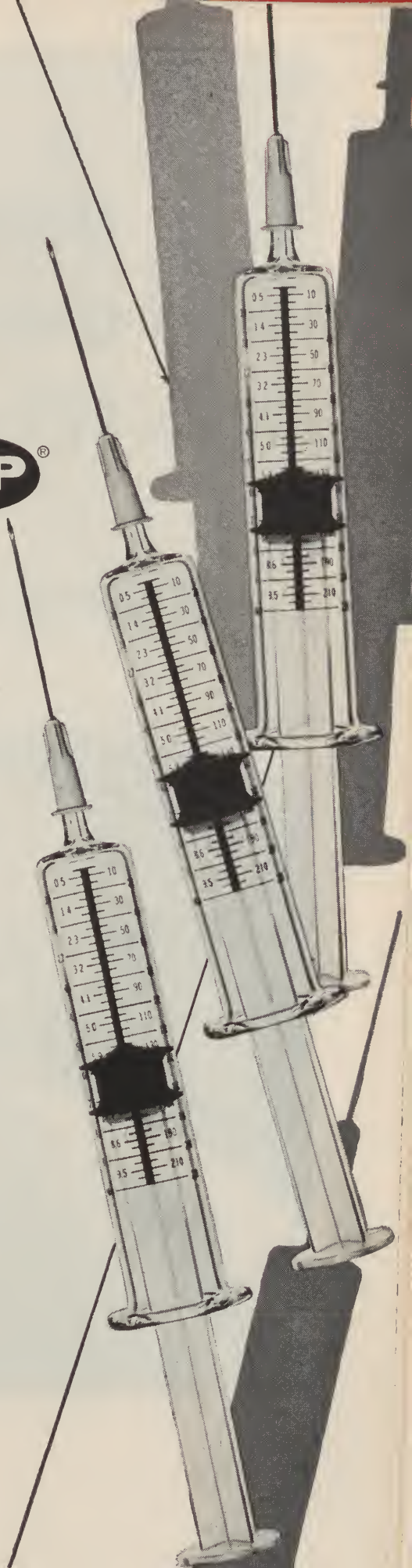


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October, 1967

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tetracycline phosphate complex-nystatin

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November 13-14

Postgraduate Course—A current view of congestive Heart Failure—Contact Sage Rasen, Assistant Director, Postgraduate Education. To be held at the Sheraton Hotel, Philadelphia, Penna.

HAHNEMANN MEDICAL COLLEGE AND HOSPITAL

November 17-18

Postgraduate Course—Human Sexual Function and Dysfunction—Contact Sage Rosen, Assistant Director, Postgraduate Education. To be held at Marriott Motor Hotel, Philadelphia, Penna.

November 26

9th National Conference on the Medical Aspects of Sports—in conjunctian with the Annual Clinicol Convention of AMA at Houston, Texas. Contact: Fred V. Hein, Ph.D., 535 North Dearborn St., Chicago, Ill. 60610.

MEDICAL ASPECTS OF SPORTS AMERICAN MEDICAL ASSOCIATION ANNUAL CLINICAL CONVENTION

November 26-29

Annual Clinical Convention of the AMA—Houstan, Texas. Contact: 535 North Dearborn St., Chicago, Ill. 60610.

AMERICAN MEDICAL ASSOCIATION ANNUAL CLINICAL CONVENTION

December 2, 1967

Regionol Meeting—Moryland and District of Columbia, 8:30 a.m.-4:30 p.m. in the Auditorium of the Medical Services Library, University Hospital, Lombard and Greene Streets, Baltimore, Md.

AMERICAN COLLEGE OF PHYSICIANS

December 4-7

4th Annuol Postgroduate Course—on Pulmonary Function in Health and Disease—in Auditorium of Louisiana State University Schaol of Medicine. Contact Alan B. Borne, Suite 407. 305 Baronne St., New Orleans, La. 70112.

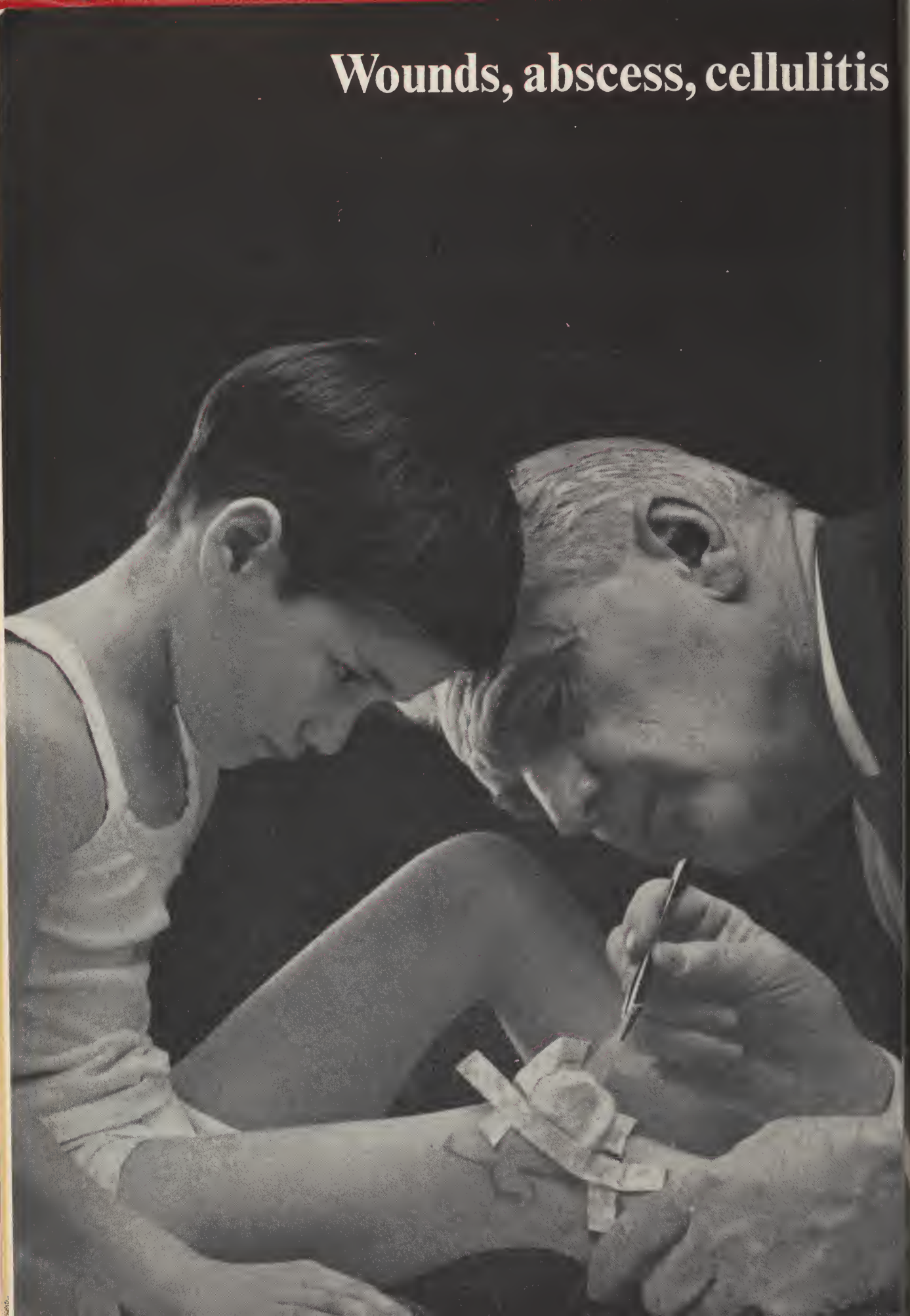
LOUISIANA THORACIC SOCIETY

December 10

Board of Directors Meeting—Moryland Room, Holiday Inn Downtown, Baltimore, Md. 11:00 a.m. Contact G. Overton Himmelwright, MD, 133 Virginia Ave., Cumberland, Md. 21502.

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PRESCRIBING INFORMATION: For complete information, consult Official Package Circular. *Indications:* Infections caused by Staphylococci, particularly those due to penicillin G-resistant Staphylococci. *Contraindications:* A history of severe allergic reactions to penicillin. *Precautions:* Typical penicillin-allergic reactions may occur. Safety for use in pregnancy and premature infants is not established. Because of limited experience, use cautiously and evaluate organ system function frequently in neonates. Mycotic or bacterial superinfections may occur. Assess renal, hematopoietic and hepatic function intermittently during long-term therapy. *Adverse Reactions:* Skin rashes, pruritus, urticaria, eosinophilia, nausea, vomiting, diarrhea, fever and occasional anaphylaxis. Rare cases of reversible hepatocellular dysfunction have occurred. Moderate SGOT elevations have been noted. Thrombophlebitis has occurred occasionally during intravenous therapy and leukopenia was noted in two cases. *Usual Oral Dosage:* Adults: 500 mg. *q.* 4 or *q.* 6 *h.* Children: 50 mg./Kg./day. *Usual Parenteral Dosage:* Adults: 250-500 mg. *q.* 4 or *q.* 6 *h.* Children: 50 mg./Kg./day. Treat beta-hemolytic streptococcal infections for at least 10 days. Give oral drug 1 to 2 hours before meals. *Supplied:* Capsules—250 and 500 mg. in bottles of 48. Injectable—250 mg., 500 mg., and 1 Gm. dry filled vial for I.M./I.V. use. For Oral Solution—100 ml. bottle, 250 mg./5 ml when reconstituted. **A.H.F.S. CATEGORY 8:12.1**

References: 1. Abstracted from *Antibiotic Sensitivity of Staphylococci Studied from November 1962 through August 1965,* reported by Griffith, L.J., Staphylococcus Reference Laboratory, V.A. Hospital, Batavia, N.Y. 2. Data on file, Bristol Laboratories.

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During the 2½ day program all aspects of a community's emergency medical services system will be discussed in terms of identification, coordination, and implementation. This system includes: first aid and emergency care, transportation of the ill and injured, emergency communications, and emergency facilities.

Special emphasis will be placed upon the development of Community Councils on Emergency Medical Services and ways and means of financing the community's emergency medical services system. Roles of the US Department of Transportation, Public Health Service, state government and organized medicine also will be discussed.

The conference is open to all persons involved or interested in their community's emergency medical care. This includes physicians; allied health personnel; hospital administrators; providers of ambulance services; public safety officials—police, fire and sheriff; government officials—local, county and state; representatives of service organizations; planners; educators; and private citizens. A cross section of the various national leaders of the above groups will be featured on the conference program.

An added highlight will be industrial and organiational exhibits related to the various aspects of the emergency medical services system.

For further information, write to: *AMA,* Department of Hospitals and Medical Facilities, 535 North Dearborn Street, Chicago, Ill. 60610.

MARYLAND HEALTH FAIR—SPECIAL EVENTS OF INTEREST

The largest and most significant educational event for better health in this state—the Maryland Health Fair—will open next November 11 at the Baltimore Civic Center and continue from 10 a.m. to 9 p.m. daily through November 20.

Occupying the entire exhibition area of the Center, the Health Fair will present an expansive program of demonstrations, lectures, classes, special displays and will have approximately 250 booth areas filled with exhibits on all types and phases of health information. The Fair is free to everyone and there are no fees or other charges for any of the special programs.

The Health Fair is drawing its expected audience of more than a quarter of a million from the entire Maryland area as well as the District of Columbia, Pennsylvania, Delaware and New Jersey.

The lower area will house some 200 displays centered around the huge "Space Medicine" exhibit provided by the National Aeronautics and Space Administration. It describes the major medical advances which have occurred in the past decade and their relationship to the US space efforts.

Another major exhibit includes the 40 paintings by the international artist, Robert A. Thom, which immortalizes pictorially the highlights of pharmacy from antiquity to the present. Commissioned by Parke, Davis and Co., the "Million Dollar" series was completed after ten years of research and more than 250,000 miles of travel to all parts of the world.

Most outstanding of the ten displays loaned to the Fair by the *AMA,* is the *Transparent Twins,* two life-size transparent plastic female models, one showing 25 organs of the body and the other the 200-bone skeleton and the nervous system.

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Other *AMA* displays cover such subjects as medical quackery, alcoholism, human conception and birth, drug addiction, sight, hearing and weight reducing.

On the upper level of the Civic Center a series of small auditoriums will be used for continuous movie showings, special lectures and demonstrations. A second area will be occupied by a health screening test center where free tests will be given blood pressure, diabetes, vision, dental and hearing. An adjacent area will be used for individual consultation on problems of the aging, Medicare and allied subjects.

Sponsored by the ten member health agencies of the Commerce and Industry Combined Health Appeal in conjunction with the *Medical and Chirurgical Faculty of Maryland*, the Maryland State and Baltimore City Health Departments and the Hospital Council of Maryland, the Health Fair also is receiving much of its support from other voluntary health agencies, public health departments, local and national governmental agencies, medical schools, hospitals and allied professional groups.

* * * * *

SINAI OFFERING SPECIAL TRAINING IN COMPREHENSIVE MEDICINE

Applications are being accepted for training in comprehensive (psychosomatic) medicine in the Departments of Medicine and Psychiatry at the Sinai Hospital of Baltimore, a 500-bed community general hospital, closely affiliated with the Johns Hopkins Hospital and School of Medicine. The training program is based on a 34-bed medical ward service with clinical responsibility and close supervision by staff psychiatrists and internists. Training stipends paying $10,000-$12,000 a year are available through the USPHS. Applicants must be either an American citizen or have a permanent visa. Inquiries should be directed to Bernard R. Shochet, M.D., Liason Service, Department of Psychiatry, Sinai Hospital of Baltimore, Inc., Belvedere and Greenspring Avenues, Baltimore, Maryland 21215.

SUICIDOLOGY

The Department of Psychiatry of The Johns Hopkins University School of Medicine is conducting a fellowship training program in the new field of Suicidology. The fellowship focuses on the study of suicide and its prevention.

Supported by a five-year grant from the National Institute of Mental Health, the program reflects the increasing academic and community interest in suicide prevention. The object of the program is to prepare persons for a variety of roles in suicide prevention centers, emergency mental health services and in community mental health programs.

Courses will be conducted by a multidisciplinary staff from The Johns Hopkins, the National Institute of Mental Health, and selected city and state agencies.

The first year's program began in September 1967. Eight one-year fellowships will be offered for the year beginning September 1968. Candidates are being sought from a variety of social and behavioral sciences, including psychiatry, psychology, sociology, social work, nursing and public health. Stipends range from $9,000 to $15,000, depending on training and experience. Applications are now being accepted for 1968.

The program director is Seymour Perlin, MD, Professor of Psychiatry at The Johns Hopkins. Chester Schmidt, MD, Assistant Professor of Psychiatry at The Johns Hopkins, is program coordinator. The project officer at the National Institute of Mental Health is Edwin Shneidman, MD, who is Chief of the Center for Studies of Suicide Prevention. Inquiries regarding the program and requests for application forms should be directed to Dr. Perlin.

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•

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•

conference on aging and long-term care

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when:

November 2-3, 1967

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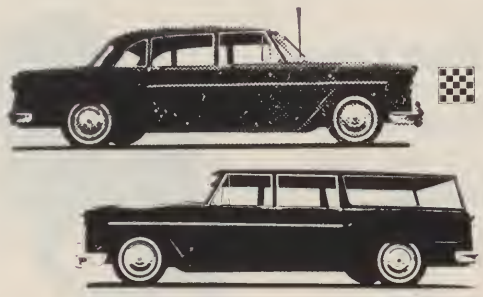
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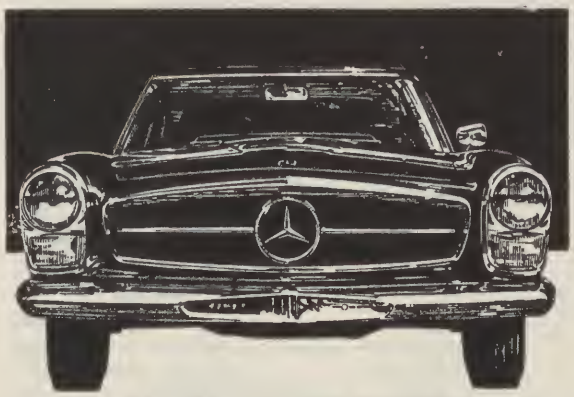
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EXECUTIVE SECRETARY'S NEWSLETTER

October, 1967

RESOLUTIONS FOR ANNUAL MEETING

Wednesday, February 21, 1968, is the date on which resolutions for consideration at the Faculty's annual House of Delegates meeting must be received in order to be considered at that time. While no date has been set for the Reference Committee meeting, adequate notice of such a date, together with the resolutions to be considered, will be provided to all members.

MEDICARE VIOLATIONS

At the AMA Annual Meeting in Atlantic City last June, reference was made to violations of the Medicare Law by officers or employees of the federal government. All such instances should be fully documented, if they occur, and reported to the Faculty office.

Once received, they will be referred to the Faculty's legal counsel for opinion as to whether or not the documented claim affords a reasonable basis for belief that there has been a violation of Section 1801, which provides that no federal employee shall interfere with the practice of medicine. If such is the case, they will then be forwarded to the AMA for action by its Legal Research Department.

MARYLAND MEDICAL POLITICAL ACTION COMMITTEE

Nearly 200 physicians and their wives heard words of wisdom from Congressman Robert H. Michel during the Faculty's Ocean City meeting in September. The Congressman spoke on Why Professional Persons Should Become Involved in Politics.

This luncheon gave added impetus to the Maryland Medical Political Action group in its activities to involve Maryland physicians in political activity.

NATIONAL HEALTH SURVEY

Adolescents aged 12 through 17 years will be examined during November and December as part of the U. S. National Health Survey. It will be conducted November 21 through December 14 and will be sponsored by the USPHS. Additional information can be obtained from the Faculty office.

MONONUCLEOSIS-LIKE CONDITIONS

A study of infectious mononucleosis, infectious lymphocytosis and related diseases is being undertaken by NIH. Areas of investigation include the virologic, hematologic and immunologic manifestations of these disease syndromes.

Full details can be obtained through the Faculty office for physicians who may wish to refer patients for these studies.

PRINCIPAL NURSING HOME PHYSICIAN GROUP

Raymond T. Benack, M.D., Silver Spring, has been elected President of the Maryland Association of Nursing Home Physicians. Other officers include, Abraham A. Silver, M.D., Baltimore, Vice-President; Allan H. Macht, M.D., Baltimore, Treasurer; and J. Raymond Gladue, M.D., Baltimore, Secretary.

On the Executive Committee are Harold V. Harbold, M.D., Baltimore, Charles H. Williams, M.D., Reisterstown, and Harvey S. Feuerman, M.D., Baltimore.

NEWS NOTES

Adrian Sanchez, M.D., Baltimore, has been named a Diplomate of the American Board of Anesthesiology.

James D. Drinkard, M.D., of Sheppard and Enoch Pratt Hospital, has been named to the Board of Directors of the Maryland Criminal Justice Commission.

Augusto J. Esquibel, M.D., College Park, has been named Assistant to the Director for International Programs at the National Institute of Mental Health. Dr. Esquibel was formerly chairman of the Faculty's Committee on Emotional Health.

Jacob H. Conn, M.D., Assistant Professor of Psychiatry at Johns Hopkins, spoke on The Treatment of Behavior Problems in the Child Patient, recently, in Philadelphia.

John Sargent

Executive Secretary

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The Month in Washington

The American Medical Association strongly opposed a suggestion that doctors' fees under medicare be based on Blue Shield schedules.

The suggestion was made to *AMA* officials while they were testifying before the Senate Finance Committee on the House-approved social security bill which includes amendments to the medicare and medicaid programs. Samuel R. Sherman, MD, San Francisco, chairman of the *AMA's* Council on Legislative Activities, said there would be heavy opposition from the medical profession to any change from the present usual-and-customary fees.

Milford O. Rouse, MD, president of the *AMA*, gave general approval to the bill passed by the House which, he points out, incorporated a number of changes recommended by the *AMA*. He said further substantive changes better could await the knowledge that one or two more years of experience would bring. However, he urged that consideration then be given to major changes in Medicare Plan B which covers physicians' services.

"We believe it is possible for the Congress, the medical profession and others interested in the subject to develop a new mechanism for delivering medical care to people over 65 that would be consistent with existing private sector mechanisms," Dr. Rouse said.

". . . the Congress realizes it has an open-end program with rising and perhaps uncontrollable costs. We believe that it is possible, and would be eminently practical, to devise another approach that could solve problems which beset Part B. One possibility, for example, might be to substitute for the Part B program a subsidy to all eligible persons, to be used for the purchase of private health insurance. Such an approach could have many advantages.

"The eligible over-65 patient would have a qualified private insurance program of his choice, at no greater expense than he has under the Part B Medicare program; carriers would have a greater responsibility for their own performance with an opportunity to exercise initiative; the physician would continue to deal with his over-65 patient in every respect in the same way as he did before the patient's birthday; and the Congress would have a program with defined costs, and one which would offer the nation a comparison of mechanisms in use to meet the problems of financing health care of the elderly."

Other points in the AMA testimony included:

Beginning with the provisions of Title 18 (Medicare), the (House) bill does not place the disabled of all ages under Medicare, as had been proposed earlier. We think the House acted wisely in establishing instead, a special Advisory Council to study the problems related to the inclusion of this group and to study the costs involved.

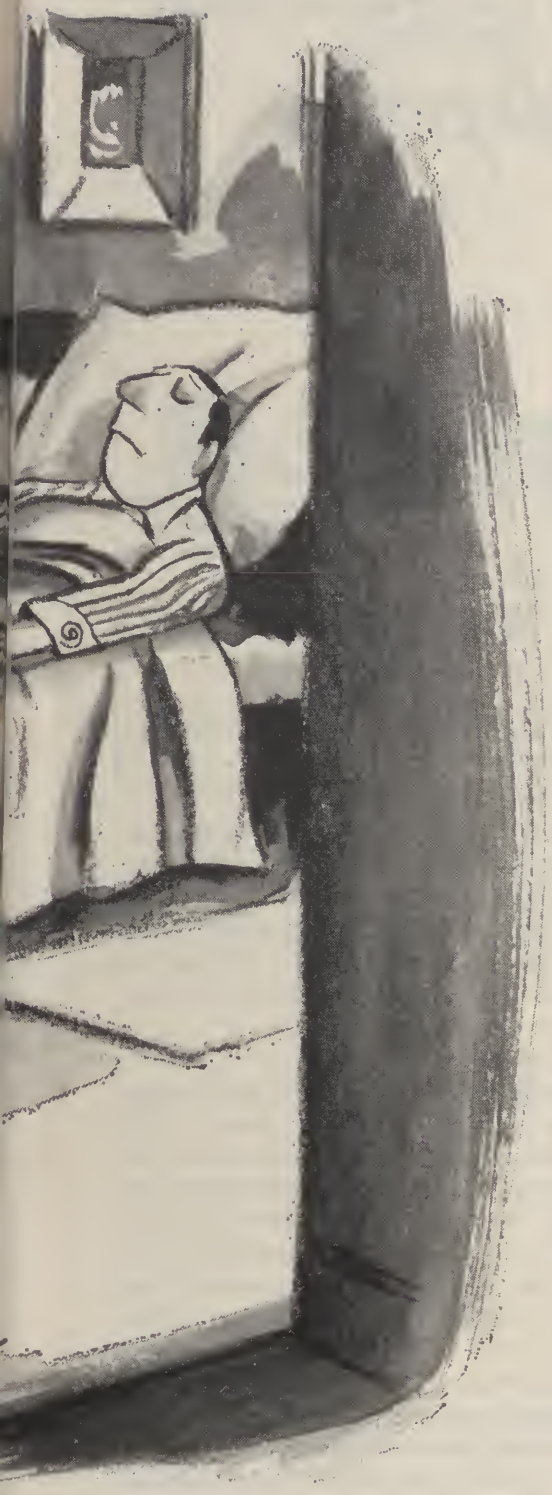
In addition to the present method of payment for physician's services, the (House) bill provides two new options: either the physician can submit his itemized bill directly to the carrier, in which case payment of 80% of the reasonable charge would be made to him, providing the full charges does not exceed the reasonable charge, or to the patient at his direction; or the patient may submit the itemized bill and be paid 80% of the reasonable charge. From the program's inception, the *AMA* has urged that the payment be permitted on the basis of an itemized statement of charges.

Outpatient hospital diagnostic services would be transferred to Part B of Title 18 and be subject to the deductible and coinsurance features. This is in keeping with our recommendation to the House Ways and Means Committee that outpatient services be included under Part B, and so remove the administrative difficulty of distinguishing between therapeutic and diagnostic services.

The bill eliminates both the requirement for initial physician certification for hospitalization of Medicare patients and the requirement for physician certification for outpatient hospital services. The *AMA* recommended the elimination of initial certification and the subsequent recertification. We continue to recommend the addition of this second step to eliminate the requirement of any certification, since any need in this regard will be satisfied by the work of the medical review or utilization



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review committee.

We believe that physicians, having been brought under Social Security, should be accorded the same privilege and opportunity for reaching a fully insured status as was accorded other professional groups when they were included in the program. Accordingly, we urge this Committee to consider the adoption for physicians of an "alternative insured status" similar to that permitted by the amendments of 1954 and 1956 which brought into the program many new groups of people and professional self-employed persons, including lawyers. Further, we urge this Committee to consider amendments that would "drop out" an appropriate number of years for physicians to make their eligibility for cash benefits both equitable and realistic.

We must oppose the drug legislation offered before this Committee as amendments to H.R. 12080. We would suggest that rather than to enact such legislation it would be worthwhile at this time to study in depth, all the economic and therapeutic factors which enter into the use of prescription drugs.

* * * * *

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The federal government has stepped up its campaign against cigarette smoking with the issuance of a new report and the appointment of a Lung Cancer Task Force.

A second Public Health Service report on the subject summarizes three and one-half years of research and study into the health dangers of smoking. The Department of Health, Education and Welfare said the report confirms and strengthens the conclusions of a 1964 report. The second report provides new technical data on the relationship of smoking to cardiovascular, chronic bronchopulmonary disease, cancer and other conditions.

Cigarette smokers have substantially higher rates of death and disability than their nonsmoking counterparts in the population. This means that cigarette smokers tend to die at earlier ages and experience more days of disability than comparable nonsmokers.

A substantial portion of earlier deaths and excess disability would not have occurred if those affected had never smoked.

If it were not for cigarette smoking, practically none of the earlier deaths from lung cancer would have occurred; nor a substantial portion of the earlier deaths from chronic bronchopulmonary diseases (commonly diagnosed as chronic bronchitis or pulmonary emphysema or both); nor a portion of the earlier deaths of cardiovascular origin. Excess disability from chronic pulmonary and cardiovascular diseases would also be less.

Cessation or appreciable reduction of cigarette smoking could delay or avert a substantial portion of deaths which occur from lung cancer, a substantial portion of the earlier deaths and excess disability from chronic bronchopulmonary diseases, and a portion of the earlier deaths and excess disability of cardiovascular origin.

Kenneth M. Endicott, MD, director of the National Cancer Institute, is chariman of the Lung Cancer Task Force made up of 10 physicians and scientists.

Dr. Endicott said that the group will concentrate on research for the development of a less hazardous cigarette, prevention of occupational cancer due to exposure of workers to cancer-causing substances in their working environment, and improvement of the present low lung cancer cure rate of five per cent.

Your MEDICAL FACULTY at Work

JOHN SARGEANT EXECUTIVE SECRETARY

The Executive Committee at its September 7, 1967, meeting took the following actions:

1. Heard a presentation from representatives of the Division of Vocational Rehabilitation, State Department of Education, with respect to its program for the Comprehensive Rehabilitation Center to be located on the grounds of Montebello Hospital.

2. Heard a presentation in connection with a proposed Retirement program for Faculty members under the Keogh law and recommended that the Council consider adoption at a special meeting called for that purpose.

3. Found no conflict in the by laws of the Association of Nursing Home Physicians which read, in part, " . . . set up standards of medical care acceptable to the Association . . ." The association is composed entirely of physicians and is dedicated to the objectives of seeing that nursing home patients receive the highest quality of care.

4. Approved changes in salary ranges of various job classifications, as recommended by a personnal study.

5. Authorized the Faculty's delegates to the *AMA* sessions to establish a hospitality suite at these meetings.

6. Approved a policy that employees would be honored on retirement on an individual basis, but in any event no recognition would be given for persons serving under five years.

7. Received information that a study was being undertaken in connection with Faculty space requirements for office and library for use in any future building or alteration plans.

8. Received information that the Internal Revenue Service had checked the meeting registration for those persons on the 1966 cruise convention and found no fault with the records maintained.

9. Expressed no objection to local health offices having MEDIC equipment installed, provided there was no additional charge to the Faculty's educational fund.

10. Endorsed appointment of the following physicians to the Medical Advisory Board, Department of Motor Vehicles:

C. James Duke, MD, Silver Spring, Physiatrist

Frederick P. Pokrass, MD, Sykesville, Psychiatrist

11. Selected John M. Dennis, MD, as the Faculty's nominee for appointment to the Advisory Committee to the Maryland Medical Assistance Program.

12. Authorized the annual donation of $250.00 to the Student *AMA*, University of Maryland Chapter; and suggested that this group might wish to make an annual report to the Faculty's House of Delegates as to its activities.

13. Receive information on problems being encountered by physicians with a few insurance carriers who are refusing to make payment of Usual Customary and Reasonable fees under Workmen's Compensation Insurance programs; and heard that legal action was being contemplated.

14. Received information with respect to a

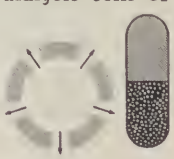


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specific problem in Prince George's County in connection with the "corporate practice of medicine."

15. Authorized the Council Chairman and Executive Secretary to meet with the Governor's Aide on Health, Welfare and Human Relations in connection with certain areas of difficulty with the State Health Department.

16. Heard that a Chiropractor had instituted suit against a physician in connection with a so-called "restraint of trade" action on a Workmen's Compensation case.

The Council met on September 7, 1967, and took the following action:

1. Adopted the minutes of Council and Executive Committee meetings.

2. Approved the financial statement and dedicated fund statement through July 31, 1967.

3. Ratified physicians' defense for various physicians requesting it.

4. Heard that two cases had been closed; one with a verdict in favor of the physicians, now on appeal; and another settled for $1,450.

5. Reaffirmed action taken at the June Council meeting denying physicians defense for a member who had failed to pay his 1967 dues by January 31.

6. Recommended Emeritus membership to the House of Delegates for various individuals at the request of their component societies.

7. Disapproved of a recommendation that would have established legislation requiring laboratories to report positive serologies and positive Tbc identifications to the state or local health department, but permitted the health department to follow up such contacts only after obtaining permission of the physician.

8. Approved the following recommendation of the Liaison Committee:

"Approval of the policy that Prescription blanks printed for physicians after January 1, 1968, *not* contain *printed* information indicating refills."

9. Adopted the following recommendations of the Liaison Committee in connection with X-ray programs offered by local and state departments:

An educational program should be directed at private practitioners in an effort to influence their referring private patients to Radiologists rather than to Health Clinics, particularly when payment is being made by a third party with greater and greater frequency.

If a pregnant woman under the care of a private obstetrician is in need of a chest x-ray, then she should be referred to a private Radiologist.

Industry requiring a preemployment chest x-ray should be encouraged to contract with a private Radiologist whenever possible. The Health Department and the Maryland Tuberculosis Association should discourage the use of their facilities by industry for preemployment x-rays where it is felt that such an arrangement with a private Radiologist is feasible.

In this connection, the Council also undertook to advise the Faculty's Occupational Health Committee and the Maryland Thoracic Society of this action; with the suggestion that Industry adopt such a policy and that the Thoracic Society consider recommending similar policies to the Maryland Tuberculosis Association.

10. Adopted the following recommendation which came through the Membership Committee:

"An appropriate recognition at the time of their death be made of members or other deserving individuals who have worked on behalf of the medical profession. The determination as to the extent of the financial cost of such tribute, and the determination as to the qualifications for such tribute should be left to the discretion of the Executive Committee."

11. Rejected the following recommendation which came from the Membership Committee:

"The Membership Committee recommends to Council that, in the Faculty's routine letter sent to widows on the death of a Faculty member, an offer be made to underwrite the cost of Blue Cross and Blue Shield health insurance for the widow, provided her financial circumstances warrant it. It is understood that such an offer, if not taken advantage of initially, would be made available at any time in the future, should circumstances change. Funds are available for this from the Cordell Fund."

12. Received an information report that the Membership Committee was still studying the question of admission of Osteopaths to membership; and also a policy that could give

guidance to the same question with respect to hospital medical staffs.

13. Received for information the report of the Subcommittee on Child Welfare on Education Programs for Pregnant Girls. This has been adopted by the State Department of Education.

14. Adopted the report of the Ad Hoc Committee to study the Abortion Law, as amended. This is summarized on page of this is sue of the Journal.

15. Approved holding a special Council meeting on Thursday, October 5, to discuss and adopt a proposed Retirement program for Faculty members under the Keogh law.

★★★★★★★★★★★★

LICENSE REVOCATIONS, SUSPENSIONS AND PROBATIONS

The Board of Medical Examiners has advised that the following license revocations have been ordered, effective on the dates shown:

Revocation:

Jesse Williams II, MD, Revoked April 20, 1967. Convicted of the crime of manslaughter, 1st degree, by the Supreme Court of the State of New York, County of New York.

Matthew M. Cox, MD, Revoked April 20, 1967. Convicted of violation of Section 11163, of the Health and Safety Code of California, a statute regulating narcotics, by the Supreme Court of California.

Suspension:

Miller Maurice Evans, MD, Suspended on June 6, 1967, pending restoration of his Virginia Medical license.

Probation:

Clay Henry Johnson, MD, placed on probation subject to continuation of his probation by the Board of Medical Examiners of Louisiana, further action contingent on the actions of the Boards of Louisiana or Texas.

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***MEDICARE APPLICATIONS ACCEPTED**

Report on Protocol on Registered Nurse Responsibilities and Duties as Related to Medical Practice Act

Discussion took place on procedures now performed by nurses and the desirability of their being in scope of practice of medicine and still being practiced by registered nurses, under the order of a licensed, registered physician who assumes full responsibility for the act. Specific permissions and restrictions may be made by the local medical staff in each hospital in the state. Generally, if the act performed by the registered nurse is basically mechanical, not requiring the exercise of medical judgment, and is done by order of or supervision by a physician, it is legal.

The following suggestions were made on the items listed, provided by the Maryland Nurses Association:

1. **Initiation of external cardiopulmonary resuscitation and artificial respiration (mouth-to-mouth or mouth-to-nose)**

This would be done as a first-aid measure, and any person adequately trained and accepted as qualified to do it would normally proceed with such action. Nurses should have a training program for the persons who perform this service. They should also be taught protective measures in training to prevent contracting a disease such as tuberculosis, syphilis or meningitis.

2. **Administration of investigational drugs**

This would be done on orders of a physician, with permission of the patient (consent form), and approval of the medical advisory committee or board at the hospitals.

3. **Administration of subcutaneous infusions**

Approved administration by nurse, with orders of a physician.

4. **Vena puncture**

Approved administration by nurse, with orders of a physician.

5. **Administration of intravenous a) Fluids, b) Blood, c) Medications, d) Medications added to fluids**

Approved administration by Intensive Care Unit IV or Fluid Team; blood given with physician, preferably a pathologist, supervision.

6. **Removal of inter-cath (indwelling intravenous catheter)**

Approved administration by nurse.

7. **Deep intratracheal suction**

No, should be anesthesiologist or anesthetist under the direction of anesthesiologist.

8. **Administration of anesthesia during labor**

No, should be anesthesiologist or anesthetist under the direction of anesthesiologist.

9. **Vaginal examination during labor**

Approved on order of physician.

10. **Rectal examination during labor**

Approved on order of physician.

11. **Removal of sutures**

Approved on order of physician.

12. **Suture of minor lacerations**

No—unqualified.

13. **Exchange fluids in peritoneal dialysis**

Qualified yes.

14. **Performance of tracheotomy**

No—unqualified.

15. **Insertion of gastric tubes**

Approved.

16. **"Milking" chest tubes to keep them open**

Approved.

17. **Interpretation of electrocardiograms**

No—unqualified.

18. **Substitute for the pharmacist in his absence**

"The night nurse supervisor is authorized to utilize the services of the pharmacy under the following conditions:

1. The pharmacist must provide an emergency pharmaceutical kit containing drugs necessary for the peculiar or particular needs of the hospital from the time the pharmacist leaves the hospital until he returns.
2. An appropriate record shall be kept in the pharmacy which the nurse shall sign, showing the name of the drug withdrawn, the exact amount of each dose, and the total

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Adopted by the Council, June 17, 1965, revised Feb. 15, 1966.



amount of each drug withdrawn.

3. For any drug not included in the emergency pharmaceutical kit, the pharmacist should be called and should provide emergency service in the procurement and the dispensing of the drug required."

19 **Application of pressure bandages to control hemorrhage**

Approved.

20. **Operation of intermittent positive pressure machine**

Approved, if properly trained.

Joint Statement on the Role of the Registered Nurse in the Care of the Patient with Cardiovascular Diseases in Coronary Care or Intensive Care Units

It has been demonstrated in recent years that patients can achieve a significant reduction in mortality from myocardial infarction. This has been made possible by the establishment of special units for the care of these patients. The general term used throughout the country for this type of unit is "Coronary Care Unit."

The basis in which this concept is derived is recognition that intensive observation and immediate recognition of the patient's changes in cardiac arrhythmia are essential. These changes take place so quickly that life-saving therapy must be instituted immediately if it is to be effective.

This statement is prepared in order to promote this life-saving kind of care, yet give some protection to the physician, nurse and hospital on a legal basis. The above-named groups (Med-Chi Faculty and Maryland Nurses Association) recognize the propriety of registered nurses using monitoring, defibrillating and resusciatative equipment. In addition, under certain conditions it is appropriate for registered nurses to institute life-saving corrective measures—if the licensed physician is not immediately available and if all other conditions below are adhered to:

1. The Registered Nurse must have had a special and intensive course of instruction in the above techniques and have the knowledge necessary for her to perform these

Adopted June 8, 1967.

duties safely.

2. Registered Nurses may be allowed to perform these procedures in line with policies carefully stated and voted on by the medical group responsible for the care of patients in the specific hospital.
3. These techniques should be carried out only by licensed professional nurses who are working in Coronary Care Units or in Intensive Care Units.
4. Only nurses who have demonstrated that they are capable of performing these tasks may be designated to do so.

Nurses should be informed that no statement of policy by professional organizations or by an employing agency can relieve the individual nurse of responsibility for his or her own acts. A statement of policy will not provide immunity from legal action if the nurse is negligent. A policy statement will give the nurse support by setting forth recommended policy which responsible professional groups suggests for appropriate practice and sound procedure.

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Statement on Closed Chest Cardiac Resuscitation and Artificial Respiration by The Registered Professional Nurse*

When available, a physician is responsible for the treatment of cardiac arrest. If he is not present he should be summoned immediately and, upon arrival, responsibility for treatment rests with him.

It is recognized that in hospitals, and elsewhere, emergencies may occur in which performance of closed chest cardiac resuscitation and artificial respiration appear to be indicated; that in these emergencies physicians may not be immediately available; and that a delay beyond a period of 3 to 5 minutes in administering closed chest cardiac resuscitation and artificial respiration to a patient may mean either permanent brain damage or death.

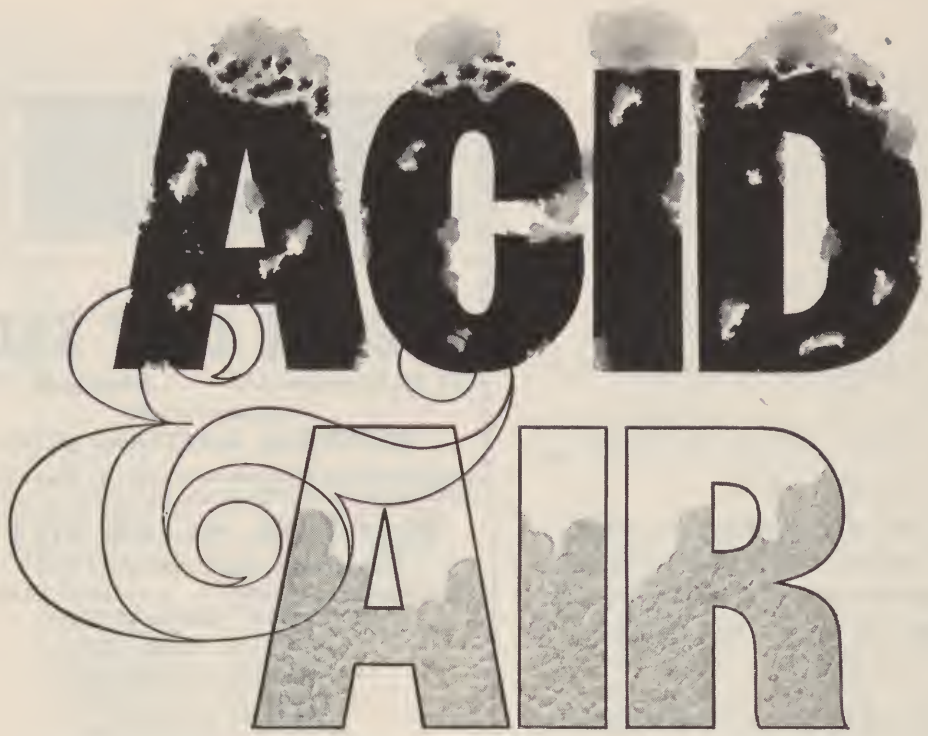
University and other hospitals have already established as common practice that appropriately trained registered nurses are authorized to perform closed chest cardiac resuscitation and artficial respiration as emergency procedures until such time as a physician arrives to assume responsibility for treatment. It is essential that a hospital assign a physician for this important duty, particularly in view of the medicolegal aspects of this responsibility.

Because in emergency situations closed chest cardiac resuscitation and artificial respiration constitute life saving, humanitaran acts, we support the role of the properly trained registered nurse in performing the above under the following circumstances:

1. The apparent need for closed chest cardiac resuscitation and artificial respiration.
2. The absence of a physician.
3. The nurse is licensed as a registered nurse by the Maryland State Board of Examiners of Nurses.
4. The nurse has been instructed in closed

Approved by the Board of Directors, Maryland Nurses Association, January 24, 1966.

Approved by the Executive Committee, Medical & Chirurgical Faculty of the State of Maryland, February 17, 1966.



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chest cardiac resuscitation and artificial respiration by a qualified physician or nurse instructor as outlined in the pamphlet entitled, "Cardio-Pulmonary Resuscitation, A Manual for Instructors," published by the Heart Association of Maryland.

5. That the employing agency i.e., hospital, industrial clinic, visiting nurse service, etc. state in its policies that these procedures may be carried out by a properly trained registered nurse and under what circumstances.
6. That there are no physicians' orders contrary to the carrying out of such procedures.

We further recommend the following:

1. That closed chest cardiac resuscitation and artificial respiration instruction and practice be included in the curriculum of all diploma, associate degree and baccalaureate degree programs for nurses.
2. That all practicing registered nurses be encouraged to take basic training in closed chest cardiac resuscitation and artificial resperiodic refresher training.
   periodic refresher trining.
3. That particular emphasis on training in this regard of head nurses and nursing supervisors in charge of nursing units in hospitals be encouraged.
4. That hospitals and other organizations, which furnish nursing care, have available and on appropriate display, instructive placards on closed chest cardiac resuscitation and artificial respiration.

*This statement was prepared for registered nurses and is not intended to limit training of other personnel. The Heart Association of Maryland is willing to lend assistance in teaching and training programs.

Statements on Intravenous Administration of Fluids, Blood, Medications by Professional Registered Nurses Practicing in Maryland

Nurses should be informed that no statement of policy by professional organizations or by an employing agency can relieve the individual nurse of responsibility for his or her own acts. A statement of policy will not provide immunity from legal action if the nurse is negligent. A policy statement will give the nurse support by setting forth recommended policy which responsible professional groups suggest for appropriate practice and sound procedure.

Development of Policies

It is suggested that hospitals or agencies desiring that professional registered nurses administer intravenous fluids, blood and medications, use the following recommendations as guides in developing written policies:

It is recognized that final decision in any interpretation of a law is in the jurisdiction of the courts.

Approved by the Board of Directors, Maryland Nurses Association, January 24, 1966.

Approved by the Executive Committee, Medical & Chirurgical Faculty of the State of Maryland, February 17, 1966.

Fluids and Medications

The procedure and specific fluid must be ordered in writing and signed by a licensed physician.

Wherever the professional registered nurse is working, the medical, nursing and administrative staffs should establish written policies which clearly and specifically state the conditions under which the professional registered nurse may administer intravenous fluids.

The following shall be included in the written policies:

1. The specific requirement for instruction and supervised practice.
2. A requirement that the administration of intravenous fluids and medications by professional registered nurses be performed under medical supervision.
3. A requirement that a current roster of nurses who have had sufficient supervised practice and instruction and who have demonstrated satisfactory ability to perform the procedure be included.
4. A current list of specific solutions which a

professional registered nurse may administer and of specific drugs which he or she may add to the solution. This list should be reviewed and revised at designated intervals.

5. Provision of continuing inservice education.

Transfusions

The above policies should apply to transfusions of whole blood and/or blood derivatives. In those situations where whole blood or blood derivatives must be administered by a nurse, it is imperative that the nurse work directly under medical supervision, preferably the hospital pathologist or physician who has been appointed in charge of the blood bank.

Explanation of Terms

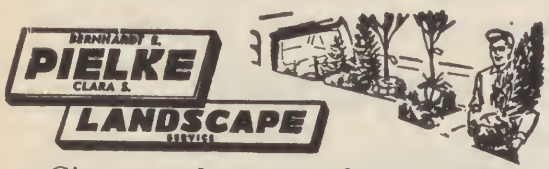
Supervised practice and instruction: It is not feasible to construct one specific instructional pattern for use in the many varied existing agencies. Instruction should be based on a formal course which teaches the principles of intravenous therapy and provides enough supervised practice to insure the development of sufficient skill for safe performance of the procedure.

Professional registered nurse: A graduate of a professional school of nursing, currently registered by the Maryland State Board of Examiners of Nurses.

Intravenous administration: Introduction into a vein where the procedure involves vena puncture by needle but does not involve incision into or incision to reach a vein.

Medical supervision: A physician is immediately available.

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Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes. A rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth — dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

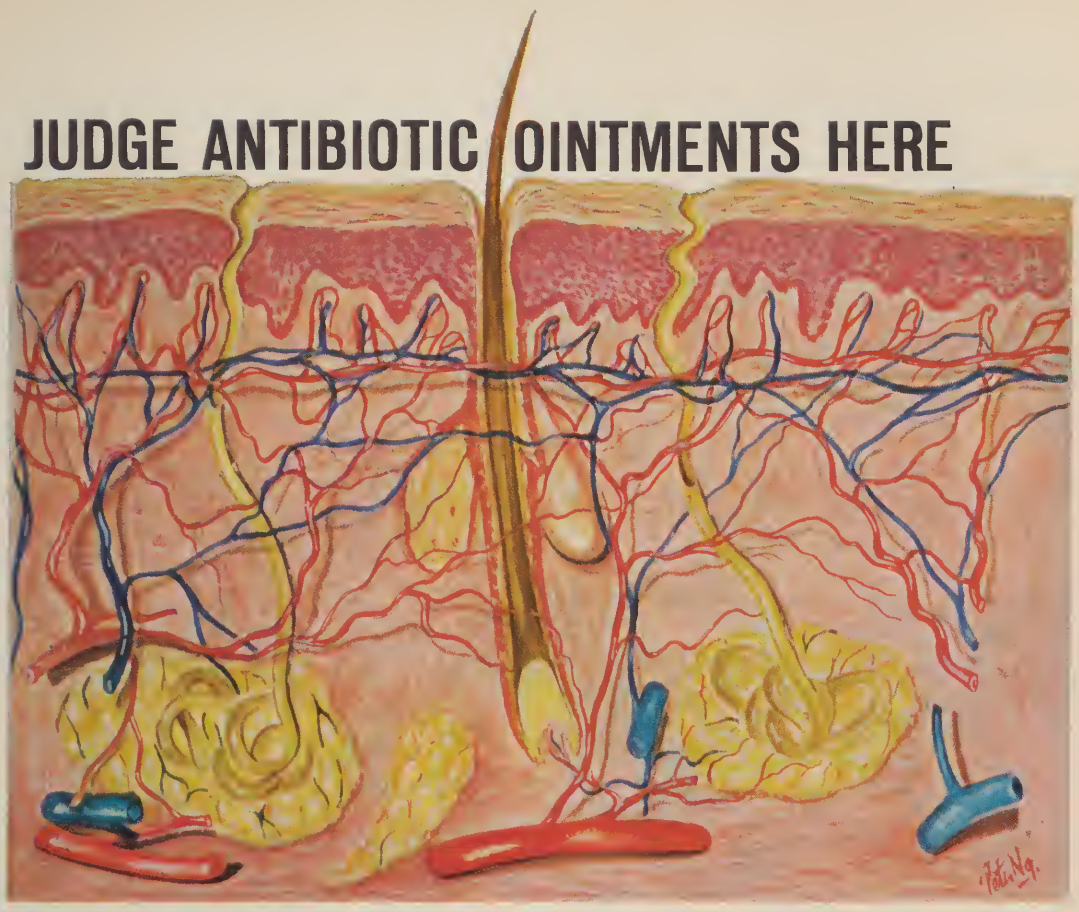
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Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

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Contraindications: Hypersensitivity to any ingredient.

Precautions: As with all phenacetin-containing products, avoid excessive or prolonged use.

Side Effects: Side effects are uncommon—nausea, constipation, and drowsiness have been reported.

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References: 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rawls, W., et al.: Med. Times, 87:818, 1959.
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When the agitated geriatric disrupts the home...

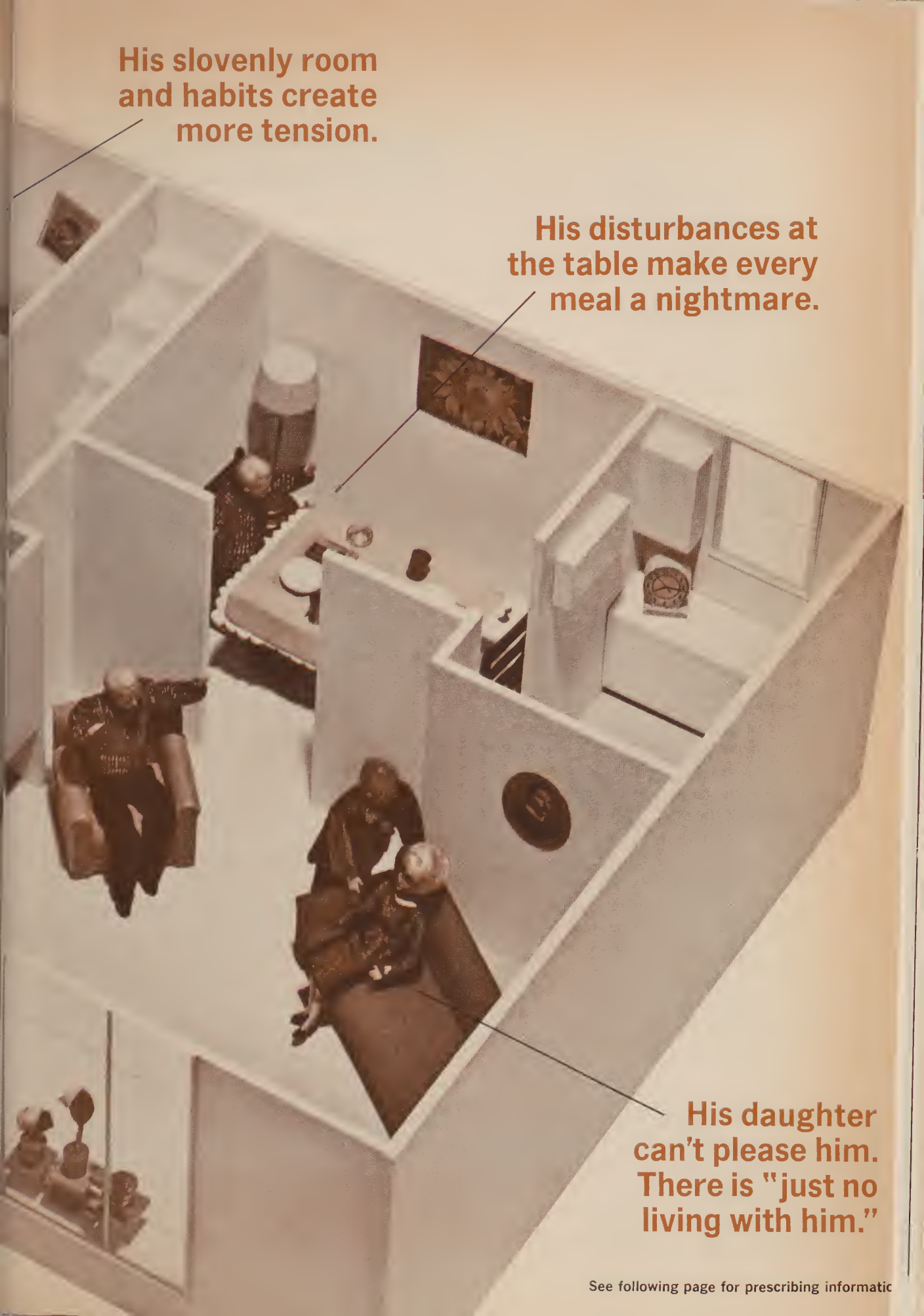
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- frequently helps strengthen emotional resources
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Thus, when you consider the anxiety moderate to severe... consider Mellaril.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

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EDITORIAL

Sports medicine gives physicians a chance to apply their special competences to fields of energetic fun and competition.

Sports now involve people of all ages and both sexes in physically stressful and physiologically demanding activities. Our patients can often afford sports equipment with which they must train constantly if they are to use it safely. Self-contained underwater breathing apparatus (SCUBA), parachutes and skis are only three examples. Youths and adults travel widely to follow their dearest sports and, in the process, expose themselves to unknown diseases and unfamiliar medical care systems.

Closer to home we have the regular and organized sports activities of secondary schools where special hazards exist for our own adolescents. Although young children and college students face definite sports dangers, both of these groups are somewhat better protected by either the lesser demands on the younger ones, or the larger professional staffs which surround and support the older. But almost all of the caretakers of the adolescent athlete– parent, trainer, physician even—have paid him relatively little attention.

Faculty members with concern for the health of our youthful athletes have started to give medical support to them and their coaches and trainers. Component societies in Montgomery and Washington counties have conducted seminars on the medical aspects of sports and, most recently, one was co-sponsored by the Faculty and the Catonsville Community College. With emphasis on prevention and on early recognition of injuries, these conferences supply knowledge and experience, support a coach who has no school physician and protect eager athletes who are new to competition. Team physicians learn the fine points of field diagnosis in team sports, the choice and fitting of safety equipment, player fitness and physical conditioning, and how to refine and improve his professional skills to further sportsmedicine.

Leaders in high school sports, knowing them to be highly competitive and dangerous, call to us physicians for the help which only we can give. But simple attendance at a football game or other contact sport is not enough. Each sport, each team has its own vulnerable spots which the team physician should know well if he is to be effective. The Faculty and its Subcommittee on the Medical Aspects of Sports can advise or consult with team physicians, send them free pamphlets on preparticipation medical examinations, and loan books on sports and athletic injuries from its library.

Physicians who enjoy sports and youth (and who doesn't!) will find that he has much help and encouragement from his colleagues, from trainers at the schools, from concerned parents—and from a fine bunch of strong kids who need him badly. Please, won't you sign on as a "Team Doc?"

JOHN B. DE HOFF, M.D., M.P.H.
Baltimore, Maryland

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HEAT ADAPTATION AND INJURY IN FOOTBALL PLAYERS



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Although deaths among high school and college football players in this country are rare, a few do occur each year. Most of these are accidental and basically not preventible (assuming the usual precautions of adequate equipment, training, etc.). Unfortunately, some of the deaths are due to heat stroke, and these must be considered preventible. From 1960 to 1963 thirty deaths among high school football players were reported and of these five 16% were attributed to heat stroke[1] and therefore presumably preventible. For the 1966 season one of 26 high school football fatalities was due to heat stroke[2]. Certainly many of the late summer and early fall practices and games, in most areas of Maryland are carried on in conditions of temperature and humidity which could be dangerous for the unprepared athlete.

It is the purpose of this paper to present the physiologic problem and hopefully to suggest certain prophylactic measures so that no such preventible tragedies occur in the State of Maryland.

PHYSIOLOGY

Heat Production: Of all the energy expended during strenuous physical exercise, approximately 25% generates productive work. The other 75% raises the body temperature. This can cause the central body (core) temperature to be elevated 4 F or more (rectal temperature of 104+F) unless this heat can be properly dissipated.

Heat Dissipation: Heat is lost from the body by one or more of the following four methods: *Radiation*, the loss of heat to objects of surrounding air which is cooler than the body, accounts for approximately 50% of the loss. *Convection*, which requires some air movement, accounts for about 15%. *Evaporation* from the skin and lungs under normal circumstances, accounts for approximately 30%. *Warming* of the inspired air and heating of food and water intake, accounts for the last 5%. Obviously all of these methods of heat loss, except for evaporation, assume that the environment is cooler than the body. Also implied is the absence of insulating clothing and the presence of convection currents of air. The percentage losses outlined are approximated only if the ambient temperature is below 80 F. Above

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this, evaporation plays an increasingly important role, until at an air temperature of approximately 95 F all modalities, except evaporation of sweat, cease to be significant. This must now account for 100% of any heat loss. In addition to the importance of air temperature, it becomes obvious that the rate of sweat evaporation is inversely proportional to the environmental humidity. The higher the humidity the less evaporation can take place and therefore the less heat can be dissipated by this means. Likewise it can be seen that the amount and type of clothing will influence not only the amount of work necessary to accomplish a given task but also the amount of evaporation which will be allowed.

ACCLIMATIZATION TO HEAT

It has been demonstrated repeatedly that individuals can be trained to better tolerate strenuous exertion in a hot and humid environment. Much of this investigation has been done in the gold mines of South Africa[5] where wet bulb temperatures of 80 F or more constitute the normal working environment. Similar work has also been done by the military in this country[6] and all results are in agreement. This training in the heat causes increased circulation to the skin and dilatation of the skin blood vessels followed by an increase in the blood volume, primarily the extracellular fluid. There is also an increased ability to sweat and to produce larger volumes of dilute sweat for a given amount of work. The same degree of exertion produces less of a rise in body temperature and pulse rate compared to the unacclimatized individual.

These changes allow the person to perform stenuous tasks in high environmental temperature and humidity, without suffering the heat injury which would occur were he not so acclimatized. It has been shown that this adaptation requires that exercise be carried on in the heat. This can be of short duration, perhaps as short as one hour a day, but cannot consist only of exposure to or rest in the heat. This alone will not allow acclimatization to take place and strenuous physical exertion must in fact be carried out in the hot environment. It implies additionally, adequate salt and water intake to replace the losses incurred by sweating as well as to allow expansion of the extracellular fluid volume.

By this method acclimatization to heat begins after several days and is approximately 80% complete in five to seven days. After two weeks of training it is virtually complete.[3,5] It should be noted however that this acclimatization can be lost. In fact approximately 50% is lost after one week with almost none remaining after two weeks.[7] This means that an individual not exercising in the heat for two weeks would require complete retraining prior to taking part again without heat illness.

Obesity and Conditioning: The state of conditioning and training of the individual seems to play a part in the ease with which he adapts to severe exercise in the heat. Piwonka and his associates at Indiana University[8] tested distance runners in April, 1963 who had not been exposed to heat since the previous summer and who should have lost any previous heat acclimatization. The authors postulated that the daily strenuous exertion of running caused frequent changes in the central body temperature with involvement of the temperature regulating responses of sweating and cutaneous blood flow which "preacclimatized" the runners. They could however be acclimatized to a higher degree and were so, beyond that which others not so physically trained, could reach.[9]

It has been observed that obese individuals acclimatize poorly to heat and may have difficulty in becoming acclimatized at all.

THE FOOTBALL PLAYER'S PROBLEM

Many if not most areas of Maryland have the conditions of heat and humidity during late August and September which could cause and have caused heat illness, injury and death among football players. These athletes are susceptible to heat injury for this sport requires extreme exertion. The uniform which they wear has been shown to increase the work load for a given task 70% above that of the same task, performed by the same individual, in a light cloth "scrub" suit.[4] When fully dressed with helmet, shoulder pads and other equipment there is little area exposed for the essential evaporation of sweat.

Many of the boys are overweight and may not be in condition at the end of summer. In this regard it should be noted that of the nine deaths from heat stroke reported in American football from 1956 to 1963 all of the players were considered large for their age and all were interior linemen.[4] Again, demonstrating the fact that some

football players may not be in condition and certainly not heat acclimatized at the beginning of football practice, it was noted that of these same deaths five occurred on the first day and two on the second day of fall practice.

THE PREVENTION OF HEAT INJURY

Conditioning: All proposed football candidates should be encouraged by their coaches to start individual training two to four weeks prior to the first organized practice session. This can probably best be done by running. It has been suggested that these boys start with running 220 followed by 440, 880 and three-quarter of a mile and finally be able to run one mile in the heat prior to the first practice. This might accomplish the preacclimatization of training and if performed faithfully in the hot weather, true heat acclimatization as well.

Salt and Water: Once the practice sessions have in fact started, the candidates must be allowed free access to water on both the practice and game field. Frequent breaks must be provided to allow water to be taken in amounts of at least four to six ounces per hour but more may be necessary. This can be given as ice water or as a salt solution of approximately 0.1%. The addition of lemon juice seems to mask the salt taste. Some of these lemon-salt solutions are commercially available but such a solution can be prepared by dissolving one teaspoonful of salt in six quarts of water and adding lemons to taste. Alternately, four teaspoonfuls of salt and six lemons can be added to one bucket of ice water.[10] They must be encouraged to take at least six to 12 salt tablets per day especially during the weeks of acclimatization, in addition to the heavy salting of food. These tablets need not be taken on the practice field but considering the frequent reluctance, it would be worthwhile to see that several are taken before and after practice to insure the intake of at least this amount. It is most important to increase and replace the salt stores of the body on a day to day basis by all available means.

There has been some evidence presented that over-hydration, before exertion in the heat, may be beneficial in preventing the heat problems.[11] It would perhaps be wise to allow free access to water while suiting up and in fact encourage the taking of six to 12 ounces of fluid during this time.

Clothing: Light weight uniforms must be used during this time of the year. They should consist of short sleeved, light weight, loose fitting jerseys without football stockings. Even less clothing than this (see Tables 1 and 2) should be used if the conditions of temperature and humidity dictate. Under no circumstances should rubber suits be allowed. They have no place in weight loss or conditioning and can only cause an excessive loss of fluid with rise in body temperature. Both predispose to heat injury and one death has been reported with the use of a rubber suit, on a day when the wet bulb temperature was only 64 F.[4] Shirts should be changed when soaked during practice and if possible, dry jerseys should be available on game days to be changed at half-time in this type of hot weather. The wet shirt close to the body forms a blanket which allows none of the essential evaporation and again predisposes to heat injury.

An important preventive measure, which should be adopted if at all possible, is the daily weighing of all candidates before and after practice. The serious heat syndromes are caused primarily by severe dehydration. This excessive loss of fluid can be appreciated prior to the occurrence of any symptoms by careful weighing. The average weight loss in a conditioned athlete will be about five pounds per practice, most of which will be regained by the next day. Any boy approaching a ten pound weight loss must be observed very carefully for this represents a fluid loss of approximately five liters. It must be insisted that he increase his intake of water on the field as well as his intake of salt tablets at home and during the day. He must be observed for the early signs of heat exhaustion. As heat acclimatization is reached, the daily weight loss will decrease as well, and therefore it can serve as an index of adaptation. As previously mentioned, the overweight or poorly conditioned individual must be watched more closely than others and these boys especially should be weighed carefully before and after practice.

Practice Schedule: On days of extreme heat and humidity practices could be held before 10 am or after 6 pm, the coolest parts of the day. The temperature and humidity should be determined daily prior to the start of each session and most logically it would be best to measure them on the

actual playing field. This is best done with a "sling psychrometer" which is relatively inexpensive and which measures both temperature and relative humidity. If this is not feasible then a telephone call to the nearest airport or weather station would give the general local conditions and might be sufficient. Suggested practice schedules and clothing are listed in Tables 1 and 2. The wet bulb temperatures of Table 2 can be directly determined from the psychrometer.

Stimulants: and certain weight reducing drugs have been responsible for deaths in athletes and should be forbidden.[1]

TABLE 1
SUGGESTED PRACTICE SCHEDULE*

Temperature	Humidity	Activities
Less than 80 F.		No restrictions.
80 to 90 F	Less than 70%	Watch carefully.
80 to 90 F	More than 70%	Ten minutes rest each hr. Change T - shirts when wet
90 to 100 F	Less than 70%	Observe carefully
90 to 100 F	More than 70%	Discontinue practice or very short program in shorts and T-shirts
More than 100 F	Regardless	

*Modified from Murphy, R. J. (1)

HEAT ILLNESS AND INJURY

A clue to the athlete suffering heat illness is the loss of mental accuracy and alertness as well as the onset of awkwardness and lethargy. Fatigue caused by strenuous exertion is manifested by a decrease in activity whereas heat symptoms are those of poor intellectual performance.

Heat Cramps: Muscular cramps most commonly in the calves of the legs (gastrocnemius) are minor symptoms. These are usually due to inadequate salt intake and seem to be worse during games rather than practice, perhaps because of the excessive sweating sustained under emotional stress. The best treatment is prevention by means of adequate salt and water intake as well as acclimatization. When they do occur, firm pressure over the area of the cramp will usually relieve the spasm. Some dilute salt solution should be administered. The athlete may return to play but should be watched for the onset of more serious heat symptoms.

TABLE 2
SUGGESTED PRACTICE SCHEDULE
(WET BULB TEMP.)*

Temperature (wet bulb)	Activities
Less than 60 F	No precaution necessary.
61 to 65 F	Alert observation especially the considerable weight losers.
66 to 70 F	Adequate salt and water intake on the field and alert observation.
71 to 75 F	Rest period every thirty minutes in addition to the above.
76 F and higher	Postpone practice or shorts and light T-shirt workout only.

*From Murphy, R. J. and Ashe, W. F. (4)

Heat Exhaustion: This is characterized by weakness, fatigue, faintness, and excessive perspiration with a cool skin. The breathing becomes rapid but the body temperature is usually normal or only slightly elevated. Nausea, vomiting and restlessness may occur. This is a more serious sign of heat injury and should be treated by the removal of as much clothing and equipment as possible. The athlete should be placed at rest and cooled rapidly with fans or ice packs and dilute salt water administered. He should also be watched carefully for decreasing perspiration and increasing body temperature. This athlete should not be allowed to play further.

Heat Stoke: This is a *life threatening emergency* and must be dealt with promptly. In addition to the weakness and faintness there is headache, confusion and ultimately coma. The skin is hot and dry with the absence of sweat and the body temperature rises rapidly. Primary treatment is the rapid lowering of body temperature by removal of clothing and equipment, ice tubs, cold

clothes, fans, etc. Immediate hospitalization is essential to avoid permanent damage or death.

SUMMARY

The time available for adequate preparation prior to the start of the football schedule is relatively short. This places great pressures on coaches and players alike to proceed with vigorous, daily training regardless of weather conditions. Heat injury, however, is preventible and the precautions outlined will allow maximum preparation with little loss of practice time, minimum loss of players from heat disability and above all no loss of life from heat stroke. These precautions are:

CONDITIONING: Encourage the athletes to train in the heat prior to the start of regular practice sessions.

WATER: There must be free access to water before and during practices and games, ie. actually present on the field.

SALT: Insist on adequate intake of at least six to twelve tablets per day and more for the heavy weight losers.

TEMPERATURE AND HUMIDITY: Check it daily prior to practice and schedule the gear, type and hour of practice accordingly.

WEIGHT LOSS: Check it for each session with special attention to the losers of ten pounds or more.

OTHER: No stimulants or rubber suits allowed.

HEAT ILLNESS: Know the symptoms and emergency treatment being especially aware of loss of alertness and accuracy.

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★★

FIELD DECISIONS—DIAGNOSIS IN FOOTBALL

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Several thousand boys in the state of Maryland are gathering on the turf for fall football practice. Some of them will be experienced, and some will be green kids, who are not in shape; but with desire and "guts," who with all their tape and pads will try to defy the laws of nature and sooner or later someone is going to get hurt.

Because of this calculated risk, there is the evolution of a new medical specialty—*"Medical Sports Medicine."* This new medical specialty has not reached the majority of physicians who care for athlete, who should be a part of the team, but lay the responsibility upon coaches and team trainers.

Why is it important to consider sports injuries as something special? Are these injuries any different from any other injury seen in the ordinary, every day practice of medicine? The answer is no, but the patient is different. The boy who sprains his ankle or pulls a tendon will eventually return to action and expose himself again. We are dealing with boys who for the most part have pride and motivation demanding a complete recovery and want it as soon as possible.

With the constant threat of mal-practice being placed upon the heads of schools, coaches and physicians; and with the popular belief that football is becoming more brutal, instead of realizing it is getting more scientific and tougher, the more knowledge one has to have, in the prevention and treatment of athletic injuries.

I feel that the most important and the toughest decisions in all athletic medicine are usually those made on the field at the time of play. It is bad enough at practice and scrimmage, but when the pressure of the clock, players, coaches, the "Monday Morning Quarterbacks," and most important the boys parents, are involved and feels like pushing the "Panic Button."

I know that everyone would like to have a rigid set of rules to follow which is impossible, but I have set down some considerations which I have followed for the past 13 years. It was not until O'Donoghue wrote his book, "Treatment of Injuries to Athletes" in 1962 that the team physician had any real guide line to follow, except from experience. I will try to outline my experiences pertaining to decisions made on the football field. For the first year football coaches and first year team physicians, there is an old football adage which states, "When your territory is in doubt—PUNT!" Get the player off the field as soon as possible, call the team doctor/or get the player into the hospital where he can be examined more thoroughly.

GENERAL CONSIDERATIONS

Knowing the boys is the first step in making a diagnosis and is of some help in making a decision. For example, when asked how he is, and he states, "I am OK, Coach, but how did the fans take it," you know the capabilities of the boy. Boys in general have a high threshold of pain, those that have a low threshold who gets a "snag

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nail" and after their bandaide is applied will be through for the game.

I feel very strongly on one point. The team physician or trainer should know the fundamentals of the sport in which he is participating. Each sport has its peculiar injuries. I also like to have some knowledge of the plays, both offense and defense. I try to attend all staff meetings of the coaches in order to learn the codes and series of plays, and I am always within ear shot of the coach on the playing field following him up and down the line observing his signals so that I might have some knowledge of what my team will be attempting to execute out on the field. I feel that the team physician should have some knowledge of the Rule Book. Rules have been made with the knowledge that injuries do occur, and some rules are made specifically for the prevention of sports injuries. Occasionally, not being aware of the rules can get one into trouble. I had one such occasion this past fall when an official was going to give me a 5 yard penalty for delay of the game, and I questioned him vehemently, but he won. During a time out called by the opposing team, I went out to check a boy whose nose had been broken earlier in the game and he had suffered some bleeding. After I had checked him, the official came over and stated that the boy had to take one play out. This I questioned. But—the rule book states, *if a team official or attendant assists a player in an official manner because of an injury, the player must be removed from the game for one play.* I caused our team to lose its star halfback for one offense play which we were starting on our own 10 yard line.

Be alert is the next consideration. I watch the field of play very closely. I am very happy when all my boys get up and go back into the huddle. I watch that long pass, or that 60 yard punt, but in the mean time, I am looking down field to see if any of those red and white jerseys are not up on their feet.

As stated above, I try to watch and make sure no one is down. If you see an injury happen, one has about half of the situation under control. If one sees a boy get hit or clipped in the knee or back, see him arm tackle, or use his arm as a flipper in blocking, one has a working diagnosis. Likewise, it is very embarassing to have the Coach tell me or one of the players that one of the team is down without my knowledge, especially, when the team is about ready to huddle. This also makes a big hit with the fans as well as the parents.

One must develop what my Coach terms "peripheral vision." One must be able to see all 22 players and not only the ball carrier. As a matter of fact, someone should be responsible for watching the entire field for every play. If there is a team trainer he should do it, or if a student trainer, he should be given some responsibility for observation of the field and players, as well as the team doctor. Don't trust the "Bench Doctor." This is the doctor who very willingly comes to care for the team as it is his night in rotation to be on call, but really watches the game like any other fan. We need this help from the medical profession, but remember, if he is not the Team's "Family" Doctor, he will not know what to expect on the play or the player. Make sure this is delegated to someone who will assume the entire responsibility.

As I have stated previously, there will be multiple pressures, from the clock, players, fans, family and coaches. But, one must remain "Cool."

The team itself also has a responsibility concerning an injury. Once the bench has been notified, or has recognized that an injury has occurred, instruct the team to keep away from the injured player. First of all, if there is blood or a twisted foot on the ankle, there may be several players instead of one to give first aid to. I insist that the team goes right back to the huddle and leave the decisions to me. Foremost, the injured player doesn't need sympathy now as it may be the wrong kind at this point.

I carry with me onto the field sterile pads, some plain bandaids, and scissors. I also have with me a little bag which I carry at all times. This bag contains: Tongue Forceps, Nasal Tube, Tongue Depressor, and an Oral Screw. It is better to have these items along than to have a boy knocked semi-conscious and have your fingers chewed up. On the bench I have a complete field kit which contains everything possible to meet an emergency situation. I also, have what we call our "Sissy Bag" with extra braces, splints, foam rubber, felt and tape, so that we are ready to make any type of protective devices needed to treat or protect an injury from further damage.

One of the most difficult taks confronting coaches and team physicians, will be how to recognize the exceptional serious injury. These

players are all fired up, hot, sweaty, muscles are tight, and have protective pads and tape as well as foam rubber and felt on almost every conceivable area of their body. Fortunately, approximately 95-97% of all injuries are of a minor nature, and the serious injury is rare. But, it is the rare one you get *penalized for* if it is *fumbled*. It is important that someone be present who will be able to rule out the exceptional one and who is prepared to handle the more common or less serious injuries. It is important that coaches or trainers sit down with team physicians to discuss these problems.

I have discussed previously some of the team's responsibility to injuries. I feel it is equally important that the entire squad should and must be aware of the fact that each injury deserves attention. An injured player is not much use to himself and is quite a disadvantage to the team. We make it a point that the Quarterback or Defense Captain is responsible to see that no one on the squad who is incapable of giving 100% effort, with full speed be permitted to continue playing. All the Quarterback or the Captain of Defense has to do is before he goes into the huddle, is to step aside, raise his arm, and point to the player and we pull him out of the lineup for evaluation.

PRIMARY CONSIDERATIONS ON THE SIDE LINE

As soon as an injury has occurred, get out onto the field as quickly as possible. In fact, I have gone out sometimes before the whistle has sounded, especially if I see the play and the injury has happened in our back field and the play is much further ahead. While I am getting out onto the field I hope to have some idea of what has happened. I worry whether or not it is a major or minor injury. Can I keep the boy playing, and will it be possible to keep him safely in the game without being re-injured.

A MUST for each team is a stretcher which is quickly available and not kept under the stands or in the locker room. Designate someone, either the Student Trainer or the Team Manager, to always have the stretcher close to the bench for practice as well as game time. Each school should have a set of "Pneumontic Splints," the type that you zipper and then blow up over the part that is injured.

I am slow to use a stretcher, as I feel that it is a psychological disadvantage to my team and a psychological advantage to the opponent team, especially if it is one of my stars that is hurt. However, this does not mean that I don't use a stretcher when the need is present, but I don't feel that it is necessary to move every injury off the field with a stretcher. *Never*, take a player from the field with his head "bobbling" and rolling or with his feet dragging. Always, use the stretcher in these cases.

PRIMARY CONSIDERATIONS AFTER GETTING ON TO THE FIELD

Never straddle an injured boy as one may end up as an injury oneself; and try to make a quick and accurate interpretation of the injury. Unloosen the chin strap of the helmet. If your player is conscious and he can talk with you, about 90% of your problem has been solved, at which time remove his mouthpiece, and put it away for safe keeping. Ask the boy what happened to him. He can tell one the history, and where he hurts, and then go on from there. If he is dazed or stunned, is his condition due to blood loss, or head injury? How do I know if he is confused or dazed? I use the technique of asking where he is, what team he is playing, his number, position on the team and what the last play was, what play was called and who he was "keying." At that moment I am not worried about his remembering the date, what he had for supper or who the President of the United States is. Use the language of his environment.

Is he having labored or difficult breathing while talking? Is he bleeding and does he have a laceration? Does he appear shocky, pale, clammy, or more than usually listless.

Next, I observe, and try to work with him for the length of the time out. I try to avoid a long drawn out discussion. However, a decision should be brief and as quick as possible. Generally, an official will be within ear shot and will permit this time out. The player is going to have to sit one play out anyway so take the time to make a final decision on the side line.

Once I have decided to permit the boy to get up, I generally ask him if he can make it off the field along with help from the student trainers. I generally tell him that his parents and fans are

looking on and if he doesn't feel that he can go off without help to tell me. Quite often, however, I make this decision for him. I always get the boy up slowly, let him sit up first before standing. If I am going to use the ambulance, I just stand up, face the ambulance and hold my right hand up in the air. This must be worked out with the ambulance crew.

There are times when there may be doubts as what to do on the field, and how to transport the player and what to do once a conclusion has been reached as to the type of injury.

SPECIFIC CONSIDERATIONS

Head Injuries

The player in general will be sprawled out on the ground. I usually attempt to turn the player on his back to examine him, unless he can tell me his back or neck bother him. If he is conscious with a headache, I go through the routine of finding out if he has any numbness or tingling in his extremities.

If he is conscious, but apparently stunned, I go through the routine discussed previously concerning his number, etc. I may give him a few "whiffs" of an Ammonia Cap at this time making sure not to get too close to his nose. If he does not respond after a few seconds, take him off on a stretcher. However, if he is unconscious, he might have multiple injuries. At this point I check his breathing, and examine him for mud in his nostrils, mouth, and ears. At the same time checking whether or not he has blood in these areas. Remember, blood coming from an ear is a serious and grave injury. Also take a look at the pupils of the eyes, and if they are not equal in size, this is real trouble. Remove this individual as soon as possible from the field, right into the ambulance.

Check to see if he has swallowed his tongue. Look in the mouth and if you do not see the tip of the tongue, but only a pink mass, this individual has swallowed his tongue. Use your fingers or a tongue forceps and pull out the tongue.

It may be that his jaws are locked and it will be necessary to use the oral screw to unlock the muscle spasms which will hold the mouth shut and jaws together. Get his mouth open and get right onto the tongue. Here is also the time to insert the nasal tube down the nose in hopes that it will give the boy an airway in back of the tongue. Always check the back of the throat after establishing an open oral passageway. For this reason no football player should be permitted to chew gum or have anything foreign in his mouth except the tooth protector, in the event he is knocked out, the foreign substance may be thrown back and lodge in the throat, cutting off the air.

Remember, the time element is only 3-4 minutes; and if not accomplished, the player will turn blue-purple. I have with me on the field a do-it-yourself-kit for a tracheotomy, a special needle which can be purchased with instruction for performing this emergency procedure. I have not had the experience of having to use one of these. But, I am ready if need be. This is a freak accident, but a 79¢ oral screw and a tongue depressor is a small price to pay for saving a life.

Your rule should always be that the team physician or some physician should be the determining factor when a player returns to the line up following a head injury.

Neck and Back Injuries

Injuries to the neck and back can be of a very severe nature. Fortunately, most of the time your player is conscious. He may say he has pins and needles going down his arms or legs which is always an indication of a severe injury. If it is a neck injury, I immediately ask him to raise both hands over his head and then ask him to grip my index and middle fingers in his hands as hard as he can. In this way one can check for weakness which can result from a severe neck injury. Occasionally the players tackle with the side of their neck and shoulder, and be suffering from a lateral-flexion neck injury which may not be serious.

I always ask the player to raise his legs straight up when he complains of back injury. If he can do this, he probably doesn't have a serious back injury to the spinal cord. Occasionally we see temporary muscle spasm that will release in just a few seconds.

Now for the helmet. As stated above, on most players if they are conscious, I remove the helmet. However, if one feels the neck is involved in a serious injury, leave the helmet on. Another point to remember is this. A helmet doesn't come off like an ordinary hat, and it doesn't screw off. Whoever is responsible for the Injury Program and all team members should be taught to take a

helmet off properly. It should be released from the ears and tilted off.

With a neck or back injury, I use 5 people to remove the player from the field onto the stretcher. It is of great value here to have an ambulance crew that have been trained in neck and back injuries. Four persons, two on each side lift simultaneously, with the 5th person at the head of the stretcher holding the head and neck very securely and straight.

What does one do on the practice field when no doctor is around? Make the player as comfortable as possible, leave the helmet on, and place two hand dummies along side of the head and call the ambulance and doctor immediately. The ambulance phone number as well as the doctor's phone number should always be on the wall just above the phone which is used for emergencies. Then call the player's parents.

FRACTURES

Although fractures are a common football injury, these are not the major problems. Fortunately, most of them are evident. If a deformity is observed about an extremity, face or nose, it is a fracture until proven otherwise. Always splint the extremity. If it is an arm, the player may walk off the field. If lower extremity, use the stretcher even though the player states he can bear weight. Fig. 5

UPPER EXTREMITY INJURIES

a. If the player is on his feet and can't raise his arm above his head, one must rule out a fracture of the arm, collar bone, or separated shoulder (A-C Separation).

b. If the player holds his arm out away from his body with the forearm flexed slightly and splints the forearm with his good arm, this is a dislocated shoulder until proven otherwise. On closer examination, one would also note that the deltoid bulge is also flat. Fig. 4

c. If the player comes out holding his arm and states he has pain over his shoulder, and he has pain on any effort to distract the joint, or if when one takes the arm and pulls down and then tries to place the arm in marked abduction (pull away from the body), the rule of thumb is that of a separated shoulder, or severe sprain of the Acromio-Clavicular Ligament until proven otherwise. Or if the step sign of the shoulder is observed a diagnosis can be made. Fig. 1, 2 and 3

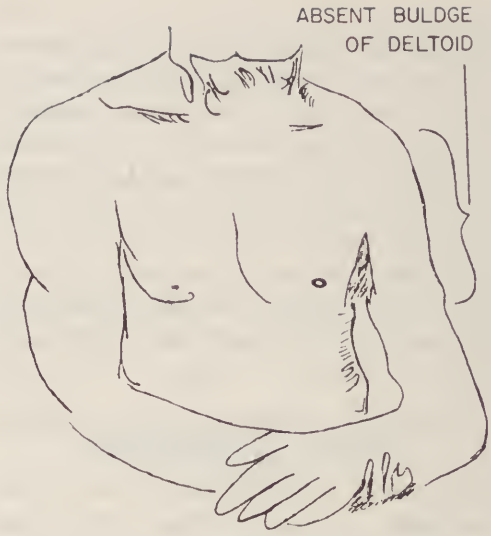


Figure 1
Dislocated shoulder. The arm is held away from the side, the flat deltoid muscle.

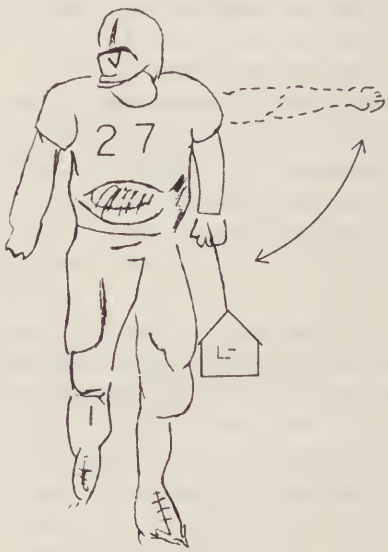


Figure 2 ←

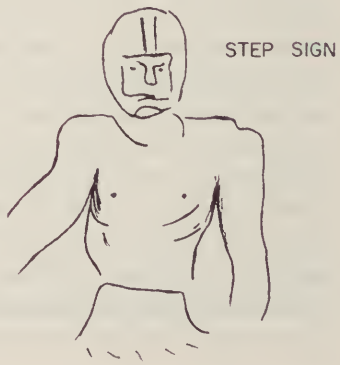


Figure 3 →

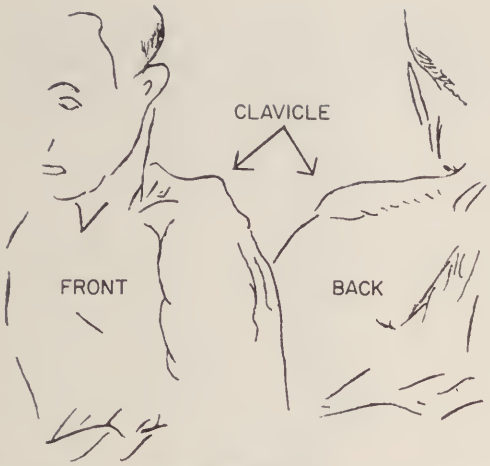


Figure 4
Step sign. Shows the upward displacement of the outer end of the clavicle in complete Acromio-clavicular separation.



Figure 5
Fractured hip. Shortening of the affected leg, with marked external rotation. Player cannot move hip.



Figure 6
Dislocated hip. Thigh flexed, adducted and internally rotated.

LOWER EXTREMITY INJURIES

HIP

a. If the player complains of pain in his hip, check the alignment of both legs. If one leg seems shorter than the other and is rotated outward, this is a fractured hip until proven otherwise. Remove on a stretcher. Fig. 5-6.

b. If the player complains of pain in his hip, both legs appear equal in alignment and the player has trouble raising his leg and swinging it outward. Check for a hip pointer.

c. Always ask where it hurts. Feel this area as you may be able to detect a deformity. Fig. 7.

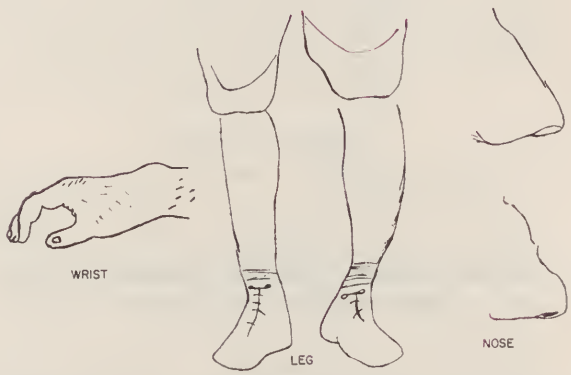


Figure 7
Possible areas where deformities may be detected.

KNEES AND ANKLES PROBLEMS

The most common areas that are injured on the field of severe nature are those of the knees and ankles. The knee injury is probably the most serious of all athletic injuries, excluding the head. Knee injuries in the high school and college athlete are just about as common as the ankle injury. The coach should not be responsible for the final decision as to return of play for a player with a knee injury. The biggest decision a coach has to make is how to transport the boy from the field.

KNEE

a. Quickly check the position of the foot and leg with the uninjured one, as there may be a hip injury with referred pain to the knee. If the play was observed the diagnosis is easier. There may be a deformity in which the entire leg below the knee is twisted completely around.

b. Check the position of the knee cap and feel it. If it gives or cracks under your fingers, there may be a fracture until proven otherwise.

c. Next check the full range of motion of the knee. If the knee is locked (Slipped knee or the ligaments. Fig. 8.

d. Rule of thumb: If the player has severe tenderness at the mid joint of the knee, there are possibilities of an injured cartilage. Fig. 9

e. Rule of thumb: If the player has severe tenderness with marked limitation of motion above or below the midjoint space, then there may be a tear or sprain of one of the collateral player will tell you he felt it go out of place) you are dealing with torn cartilage—Menisus. Fig. 10.

f. Most knee cases will involve the medial or inside wall of the knee joint. Always use a stretcher.

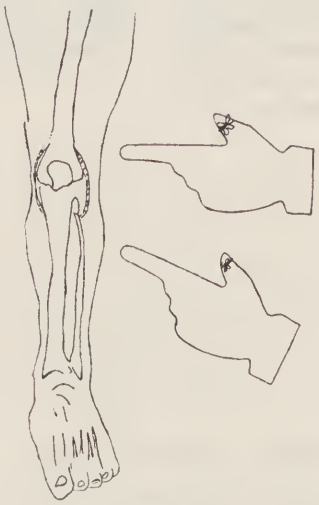


Figure 8
Collateral Ligament. Severe tenderness directly above or below the mid-joint.

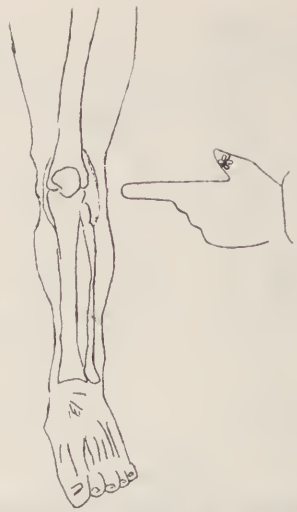


Figure 9
Cartilage Injury. Severe tenderness at the mid-joint space.



Figure 10
Marked limitation of motion above or below the mid-joint space may mean a tear or sprain.

g. If the player doesn't have or present any of the above signs, has good range of motion, no swelling, help him off the field and further evaluate him on the side line.

h. Another rule of thumb: Immediate swelling over the top of the knee or just below the knee cap is a traumatic bursitis.

ANKLE

a. Ankle problems are a continuous hazard. Again the biggest decision is that of transporting the player off the field, as these injuries range from mild strains, sprains to ligament tears to fractures.

b. Check for the anatomical alignment of both feet. If a deformity of the foot is observed, use the stretcher.

If there is no deformity, remove the shoe. Cut the laces, don't untie the shoe. Keep the foot straight as possible, and give some support to the leg, ankle, heel, and foot as the shoe is being removed.

c. Rule of thumb: Put pressure on both ankle bones, (Malleoli), simultaneously, and check as to the alignment of the bone, a deformity, as well as tenderness, swelling and a possible fracture.

1. Pain above the ankle bone (Malleoli) is a potential fracture. Fig. 11
2. Pain below the bone or right on top of the foot is a potential sprain. Fig. 12



Figure 11
Pain or pressure directly above the ankle bone (malleolus) means potential fracture.

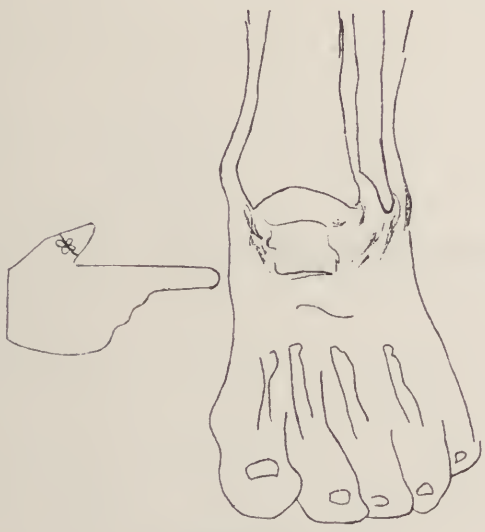


Figure 12
Pain or pressure directly below the ankle bone, and/or directly on top of the foot means a potential sprain.

SOFT TISSUE INJURIES

The less severe type of condition met on the field is that of soft tissue injury. Whether these be bruises, strains, or lacerations, for the most part, they are very minor conditions, and generally can be patched up and the player can go back into the game. There should be a "Varsity First Aid Kit" on the side lines; and if there is a team doctor, he can work right along the bench.

a. Nose bleed: One of the most common bleeding problems will be the nose. I have found the most convenient method used borrowed from Ken Rawlinson, Head Trainer at the University of Oklahoma, is the use of a Tampax. Cut a triangular wedge from this; insert it into the nose, and one has an excellent tampon for hemorrhage of the nasal membrane.

b. Lacerations: The most important step is that of stopping the bleeding. On the field I generally use a gauze pad saturated with Cramer's *Nitrotan* and apply pressure. In my opinion if the cut is not too deep and the bleeding can be controlled with a pressure dressing, I permit the player to go back on the field and then if necessary take him to the office and suture him after the game. The only decision which has to be made is whether or not the laceration will become deeper or extend if there is recurrent injury to the area.

MUSCLE INJURIES

Muscle injuries involve all different types of things. The player will mostly come out and say, "Doc, I've pulled a muscle and can't run, or every time I run I get a cramp in the front or back of my leg." This will either be a strain of the Hamstring or Quadricep muscles, or may be a "shin spint" or a "charlie horse." The latter always occurs, however, with the history of the injured part being "hit" on the affected area, with the result of swelling and pain or "Monkey Lump."

a. Muscle pull: The typical reaction of a muscle pull, which is actually separated muscle fibers, is that the player has the sensation of someone hitting him or kicking him in that area of injury. Quite often the player has never had contact and was open field running.

One can place a mild stretch on the muscle which will produce pain at the site of the muscle fiber separation. One should check the muscle and make it work or contract against mild resistance

and make sure no muscle power is lost. If it is, then use the stretcher to remove the player from the field.

RULE OF THUMB FOR TREATING INJURIES ON THE FIELD

Ninety percent of all injuries on the field will be contusions, bumps, bruises, and muscle pulls. A simple contusion or bruise is an injury in which the force or impact is transmitted through the skin to the underlying tissue with sufficient intensity to disrupt the walls of small blood vessels and to cause interstitial bleeding, increased transudation of plasma, and lymph into tissue spaces; thus, giving edema (swelling). nature immediately builds a protective wall about the injury area which is made up of body substance known as protein. This wall protects the injury, but also impedes the removal of blood, debris, and edema from the area. This wall is felt to be responsible for some of the pain in the area of the injury; and if not removed, will prolong recovery.

It is, therefore, the responsibility of the Coach, Trainer or Physician to try to immediately control the edema. This can be done by applying ice or one of the prepared "cold paks," elevating the area, if an extremity, and applying a pressure wrap. Paul C. Trickett MD, of the Tulane University, New Orleans, Louisiana, uses the word *ICE* as a reminder as how to treat. *I* = Ice, *C* = Compression and *E* = Elevation.

At Fort Hill High School, I use another adjunct in treatment of injuries on the field and that is the use of Papase(R),* a proteolytic enzyme. For the Coach or Trainer, proteolytic means the ability to break down proteins. Therefore, for the non-medical person, *PAPASE* is a proteolytic enzyme which breaks down the "Protein Wall" or barrier about the injury and permits nature to absorb the debris, edema, and blood; therefore, shortening the recovery period, permitting earlier ambulation, and decreasing pain. This drug must be prescribed by the team physician, but after using as many as 3,000 tablets a year with our team, I feel it is so safe that it can be kept on the side line, to be given to a player as soon as an injury occurs.

I sincerely hope that this summary of the steps which I take in trying to make Field Decisions and Diagnosis on the football field, will provide some practical approaches when these decisions are faced in the next few months.

*(R) Papase (proteolytic enzyme extracted from Carica papaya) Warner-Chilcott, Laboratories Div.

★★

HEAD AND NECK INJURIES IN ATHLETES

NEAL I. ARONSON, M.D.
Assistant Professor
of Neurological Surgery
The Johns Hopkins Hospital

Dr. Richard Schneider, chief of neurosurgery at Ann Arbor, has been interested in football injuries for a long time. He has published some interesting statistics. If anyone wants the references I will be glad to furnish them.

On the other hand there are some who have made the point that the face mask for instance, one of the recent acqusitions in football, may actually, while it is protective to the face, the nose, and the jaw, be detrimental to the neck. It has been shown experimentally that the further the face mask protrudes in front of the face the more of a lever arm it constitutes, in the event a player is struck with an upward blow in the face mask, it causes about double the amount of force that would ordinarily be generated by a blow on the jaw. In other words, if a man has his head in the extended position and he's struck on the face mask from the front, he gets about a hundred pounds or more of force transmitted to the upper cervical spine, and then if he has a relatively small head and a large helmet on, the back part of the helmet can catch him in the suboccipital region and create enough strain so that under severe circumstances a fracture dislocation of the cervical spine might occur. This is an area I believe that needs further scientific investigation.

Another traumatic factor perhaps is the helmet itself. With the advent of very hard plastic helmets there has been some suspicion that there is transmission of force to the skull, directly from the helmet, whereas in the older days the softer helmets caused the force to be dissipated. It is interesting to note that you do not have to produce a direct blow to the head in order to produce internal injury to blood vessels and brain and it would seem again that if some way could be developed to cause a spreading of the force rather than a direct head-on propagation from the helmet to the skull, this would be helpful.

I realize that there is a webbing inside the helmet but it does not seem to dissipate the force as well as ideally we would like it to do, and some intelligent engineer will have to work on this problem which is beyond the scope of the doctor's training to really investigate.

In one type of research, transducers are being placed into helmets during actual games in order to find out how much force is transmitted to the head through the modern hard plastic helmet.

Another thing that you have read about I am sure in the newspapers recently, and is of some importance in reference to head and neck injuries is the habit of "spearing" or "butting" an op-

Presented at Seminar on the Medical Aspects of Sports, August 14, 1967.

ponent. It seems that Dr. Schneider did an investigation of this and found that in the western colleges they teach this as a standard operating procedure in football. He finds, when he analyzes his data of serious and fatal injuries to the head and neck of which there are quite a few every year, that there seems to be a direct correlation between this type of tackling and serious injuries to the ncek and head. A recent plea has been made which was published in the *JAMA* that this type of tackling be abandoned in football and that it actually be penalized. I think I would have to agree with that conclusion.

I will begin by reviewing a little anatomy of the head and neck and then go on to discuss some of the symptoms of different types of head and neck injuries. Before doing so I think I would like to make the general plea that when a patient has a head or neck injury whether he complains merely of headache or dizziness or whether he complains of pain or stiffness of the neck, pain down the upper arm, extremities, numbness, or what have you, that the trainer think in terms of appropriate consultation before allowing the palyer to resume competition. These conditions are a little more subtle and more difficult to diagnose and are potentially more dangerous than simple sprains, strains, bumps and hematomas, bruises, and simple extremity fractures.

If a person has an injury to the neck, the simplest form is a sprain and this can be produced usually by sudden flexion or extension of the head particularly if the head is partially rotated when the force of the blow is sustained.

Football is a dangerous sport. There is no question about that, and as we get larger and larger antagonists in the game especially in the professional ranks, the amount of force that is brought to bear on the player becomes extreme. Therefore it is important to stress that people who are in this type of activity be first of all highly conditioned athletes and take regular calisthenics to keep their muscles in the best possible state of tone. That in itself is as important a preventative of injury as I know.

And secondly a man has to learn how to run. If a man for instance, is the ball carrier it has been shown that the safest running position is with his head in neutral position, perhaps flexed slightly at the waist but not flexed or extended at the region of the neck or with his head turned markedly to one side or the other. Naturally it is impossible even when rushing not to look for the hole in the line to get through but a man should train himself so that when he is actually getting into the opposing tacklers that his head return to normal alignment and that he maintain his muscles in a state of tension. There are some arguments concerning the danger of keeping the muscles tense when being tackled. It may actually provoke the fracture of long bones or extremity bones but it difinitely protects the spine. I think that highly developed back and abdominal muscles and neck muscles will prevent injury to this area of the anatomy. Keeping the head from being turned markedly to one side or the other, extended or flexed, will also prevent this type of injury as much as it is possible to do.

If there is an injury, the simplest form of injury I mentioned is a sprain and this is merely a tearing of a muscle or the ligamentous attachment of a muscle and it produces stiffness, tenderness, and some swelling locally, unassociated with any neurological symptoms. This is treated by the trainer usually with heat, usually moist heat, muscle relaxants, and rest. Rest is extremely important. Immobilization in the collar is usually not necessary for simple strains.

Occasionally when there is an injury to the neck it may be accompanied by neurological symptoms or signs and this becomes a more serious injury. For instance, the patient may complain of sudden numbness in one or both arms or his lower extremities, or he may demonstrate some weakness in the distribution of his muscles. If this is transient one can assume that the patient has merely had what we call contusion of the spinal cord. But in order for a contusion to occur there has to have been enough tearing of important ligaments arund the vertebrae to allow one vertebra to slip slightly on another or subluxate.

Now such a patient should be examined by a specialist either in orthopedics or neurosurgery and have X-rays made of the cervical spine. This is extremely important. I don't think any patient who has a neurological symptom should ever merely be treated conservatively and sent back to his duties without having films made and a consultation. I would think that if there is any persistence of symptoms such as in the case of Paul Hornung that the man should not be sent back into the lineup with one of these balloon collars

appended to his uniform but should be kept out of competition for the rest of the season. I feel that this is a potentially very serious type of injury.

We rarely, see more serious injuries to the cervical spine where there is an actual fracture and one vertebra is displaced upon another. Such a patient usually has clearcut neurological problems in addition to an extremely painful stiff neck which he is unable to move. If a patient is injured in this region of his anatomy and is lying on the football field complaining of severe pain in his neck, numbness, or inability to move his extremities, he should be moved only with the utmost caution by skilled personnel. At least five or six people should put him on a stretcher and his head should be maintained in slight traction at the time that it is done and then he should not be moved again until he is brought directly to a specialist with X-ray facilities.

Fortunately, it is very hard to produce an injury of the intervertebral disc in a normal young person. Disc injuries do occur in football but are much more common as you get into the older age groups. The men who have been in professional ball for several years and are getting up into their mid thirties are the ones that are most subject to disc injuries because a normal disc in a healthy young person is actually stronger than the bone which surrounds it. It has been shown experimentally that if you take a spine and place it in a vise, (the normal spine of a young person who has died for instance, in an automobile accident or some other cause), and put pressure on the longitudinal axis of that spine you will fracture a vertebra before you will rupture a disc.

There are some people who are subject to early disc degeneration and these people usually give the clue of having had either neck ache or backache intermittently rather early in life. People who have postural problems or people who complain of having had backache in the past, of sciatica in the case of lumbar disc, that is, pain going down the leg or pain into the region of the shoulder blade or down the arm should be seen by a specialist and probably X-rayed before they are considered to be candidates for a football squad.

Disc injuries as I mentioned are rare but we have seen an occasional disc protrusion or rupture due to a sporting injury and the treatment will depend upon the severity. The milder cases are treated by traction and immobilization in a collar followed by a period of physiotherapy. More severe cases are treated by surgical intervention. It is possible for a professional athlete or for a college player to go back after a disc excision. I would not advise it after a neck or cervical disc excision but lumbar disc injuries have resulted in sufficiently good recovery following surgical removal so that these individuals may return to active sports. One of my colleagues here in town, operated on a quarterback from Notre Dame about five or six years ago and he went back the following year and had a very productive season.

The reason for this is that it is safer to operate in the lumbar region because the spinal cord has terminated several inches above where the lumbar disc injury occurs, so that even if there were a recurrence due to a second injury it would not be of serious neurological consequence whereas on the other hand with a cervical disc you have the spinal cord to contend with and a recurrent injury to the neck could result in permanent paralysis, as the physicians at the Mayo Clinic advised Paul Hornung before he retired this year.

Sudden extension injuries or flexion injuries of the neck especially as I mentioned with the head slightly rotated produced the type of sheering force that could produce a fracture dislocation and a potential injury to the spinal cord or vertabral artery. The latter structure runs in a tunnel of bone in the cervical spine.

While on this subject I will mention injuries to the carotid artery. These are the large arteries in the front of the neck, that do not run in bone but do supply the major portion of the blood to the cerebral hemispheres or upper portion of the brain. We know of a few instances of young people developing a traumatic thrombosis of the carotid artery by a direct karate type chop blow to the neck, and the neck of course, is always to be protected. Again, fouling of an opponent should always be avoided and a man should learn to run so that the front of his neck is in a protected position. The large shoulder guards that are worn today plus the proper position of the neck will tend to prevent an injury to the carotid artery.

Here is an example in Figure I of the injury that can be caused by hyperextension of the neck with sudden blow to a face mask. This is a fracture dislocation of (45) the upper cervical region, potentially a fatal injury.



Figure 1
Note the severe fracture dislocation in the lower cervical region, and how this vertebra has slid forward on the other.

Here is a severe fracture-dislocation in the lower cervical region. Note that this vertebra has slipped forward on the other. This patient of course was quadriplegic. This was not a football injury. The man was paralyzed at the moment of impact (I believe this was a diving accident, a very common cause of this type of injury) in all four extremities and was rushed to the hospital and immediately put in skeletal traction which is where we put the so-called "ice tongs" in the skull in order to reduce this fracture and put it back into normal position. Later when the spine was examined surgically the spinal cord was found to be torn which if course meant that the patient would not recover any useful function. It is very rare to see this type of injury as a result of football, but it does occur.

According to a recent survey, head and neck injuries constitute only a very small percentage of football injuries but they account for about 80% of the deaths, so you realize that we are talking about a very important and critical portion of the anatomy.

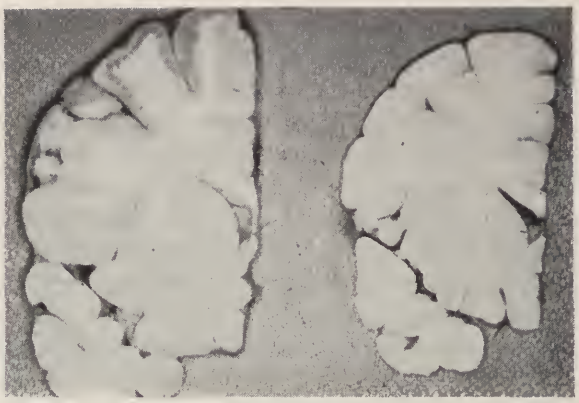


Figure 2
A section of the brain at autopsy showing cerebral edema. The left side indicates the portion most severely swollen.

Here in Figure 2 is brain which is swollen. This is a section of the brain at autopsy due to what we call cerebral edema, the result of a severe concussion. The left side indicates the portion that is most severely swollen. This is due to a collection of fluid which comes out of the capillaries and fills up the intercellular spaces of the brain.

Here in Figure 3 is a brain that has actual hemorrhage in it. This is referred to as a cerebral contusion. Note the little hemorrhages under the cerebral cortex in this autopsy specimen, and also the little petechial hemorrhages around the blood vessels.



Figure 3
A hemorrhage brain. An autopsy specimen showing the hemorrhages under the cerebral cortex.

Again it is interesting to note, that the sandlot player who does not have proper equipment would be the man you would think most subject to injuries of this magnitude, but this does not prove to be correct. Looking at the statistics you will find that the most severe injuries of the head and neck occur in the professional athlete, and I think this is directly related to the force at which these men hit and their body weight. They are now getting up into the behemoth size weighing 275 to 300 pounds and can hit with the force of a frieght train. The college athlete is second on the list. The high school athlete actually has one of the lowest rates of severe injury of this kind and I believe it is because they play a cleaner game even though they may not have as much finesse as a professional and because of the fact that we are dealing for the most part with men of more average body weight and size.

Let us turn to head injury for just a moment, I haven't discussed that in any detail. There are several gradations of head injury.

The first and most common thing that you will observe on the football field is the man who is just slightly dazed as the result of a play. If this lasts only for a few seconds and he immediately comes back to his senses I see no reason why this man should not be allowed to continue in the game provided he has no other complaints. But if the man becomes confused, and we have seen this on many occasions, he should be taken out of the game and be sent for a specialist's examination within a reasonable period of time.

In order to make the diagnosis of cerebral concussion which is (aside from scalp lacorations and abrasions and contusions) the first type of brain or head injury that we have to take into consideration, it is necessary to dicit a history of unconsciousness and a period of retrograde amnesia. This means that the individual was definitely "out" even if it was only for a few seconds, that he has difficulty remembering what transpired just prior to the time he was hit, or his memory may be entirely foggy for the period just before and just after the time that the play was run. A man who has had a concussion should be taken out of the game and regardless of how well he says he feels he should be examined by a specialists.

A man who complains, following a head injury, of persistent headache, or dizziness, of ringing in the ears, or shows confusion, falls into this category and requires further elucidation. In addition to taking a history and doing a careful neurological examination I think an electroencephalogram is worthwhile. This can show us subtle degrees of brain injury.

Here is an example in Figure 4 of an electroencephalogram showing slow-wave activity over the left side of the brain in a person who sustained unilateral hemorrage and edema following a blow to the head. In less severe injuries more subtle changes can be seen.

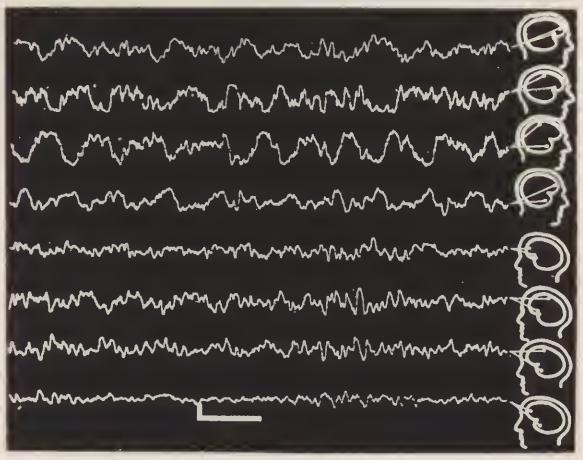


Figure 4

Now I think a man who has been seriously enough injured to produce changes in the electroencephalogram probably should be kept out of action for the rest of the season because there is a statistical chance that such a man might get late complications such as convulsive disorder or epilepsy as a result of a bad enough contusion of the brain. It is true that this rarely occurs but I think that one has to respect the brain as a very sensitive organ which is easily damaged and if the individual has shown unconsciousness, retrograde amnesia, perhaps some minor neurological changes, persistent dizziness, ringing in the ears, confusion, or anything like that, plus some irregularity in electroencephalogram, that man is entitled to be out of action for the rest of that season in my opinion.

Now the next type of brain injury I would like to mention is more severe and fortunately quite rare: is extradural hematoma. This is usually due to usually a fracture through the squamous portion of the temporal bone.

It is a well-known fact that blows to the temple are potentially fatal and this is the explanation (although there are other reasons). When the bone is fractured in this area—and usually this type of injury can only occur when the helmet has come off or when for some reason the man hasn't worn one and then receives a direct blow to the side of the head—the middle meningeal artery which is the artery that supplies the covering of the brain, the dura, can be torn because this artery runs through the bone before it gets to the brain and it runs through the bone precisely in this region, the temporal squamosa.

This of course, bleeds vigorously when it is torn because it carries arterial blood. Arterial blood is circulated under a much higher pressure than venous blood and therefore a collection of arterial blood develops over the membrane which surrounds the brain and creates pressure on the brain.

The characteristic picture of this injury is that the patient complains of excruciating headache after an initial period of unconsciousness and then gradually begins to lose consciousness again. Accompanying this there is is weakness usually of the opposite side of the body. And there may be dilatation of the pupil on the side of the injury due to pressure on the oculomotor nerve, which runs past the area involved to go on the eye.

This combination of findings constitutes a neurosurgical emergency. Six such cases were reported over a five-year period which was reviewed by Dr. Schneider in 1964 and five of them died. Theoretically, most if not all of these could be saved by early surgical intervention and that is why, if a man shows progressive changes of severe excruciating headache following a head injury he should immediately be taken to a specialist.

The next type of injury I would like to mention is the so-called subdural hematoma which is a hemorrhage beneath the membrane surrounding the brain but still outside the brain.

There was a time when we thought that injuries of this kind mainly occurred in infants or in aged people and especially in alcoholics. The reason for the latter is in early youth and late in life the brain tends to be smaller than the skull and there is more than a potential space in which bleeding can occur. However even young adults can develop subdural hematoma and in this survey conducted by Dr. Schneider which I previously alluded to, it was the most potent and most frequent serious brain injury that was seen in football players. They had some 65 cases of subdural hematoma with an appallingly high mortality rate. One of the reasons that the mortality rate was high in this group was because the acute subdural hematoma often had some arterial bleeding associated with it. The chronic subdural hematoma, the symptoms of which come on gradually over a period of a couple of weeks, is usually due to venous bleeding. Veins of course carry blood under low pressure and they tend to bleed only until they are tamponaded by their own outpouring of blood and then the bleeding stops, whereas arterial bleeding will go on more rapidly and more extensively. On the other hand, many of the subdural hematomas discovered were probably in the subacute or chronic category and these patients too could have been saved with appropriate and early diagnosis. Many of them were. But invariably some are lost.

The commonest reason for this is that in many communities specialized services are not available and this is a field in which only the neurosurgeon can participate because there is no other field that consists in dealing with diseases of the brain per se in a surgical sense. The general surgeon however who goes through a good program has had some experience in rotating through the neurosurgical training and should have the ability at least to diagnose and in some instances even to drill small openings which we call trephinations to relieve the acute pressure of subdural bleeding. Unfortunately, not all general surgeons have had such training.

If a man has a severe head injury he should be transported as soon as the local doctor feels his condition will permit to where specialized care is available. There are many diagnostic tests and tools that are available in large medical cents to facilitate the diagnosis of these conditions without doing exploratory surgery. In most instances it will be found that the man does not have such a severe injury but it is much better to err on the side of safety than to overlook an injury which might later prove to be fatal. In subacute or chronic subdural hemaloma the situation is less urgent. The patient may seem a little woozy and groggy and be confused just as though he had a simple concussion and then feel fine for several

days, but a week or so later he may start suffering from headache and periods of somnolence, ability to concentrate and may then begin to show some weakness on one or both sides of his body or some double vision When these symptoms have their advent it is the time to immediately seek consultation.

Occasionally, a man will die suddenly after a blow on the head. Some of these deaths are due to massive hemorrhage from a ruptured aneurysm. This is a congenital abnormality which weekend a blood vessel in the brain. according to an autopsy survey this is one of the rarest causes, as is brain tumor, of sudden death due to head injury. The majority of them are due to garden variety type of head injuries most of which are theoretically if not actually treatable by proper diagnostic studies and early surgical intervention.

Skull fracture itself, which I mentioned before, does not necessarily have to be a very serious type of injury but it is indicative of the force of the blow which the individual sustained and it indicates the necessity of a careful observation of that patient for complications such as intracranial bleeding. Many types of skull fracture are simple: they are not depressed; they are not comminuted; they are not compounded. In other words, there is no indriving of dirt because there is no overlying laceration in the majority of instances and they are not pushed into a position where they create pressure on the brain. These may just be treated by simply watching the patient until they heal. I would think that a man who has had a skull fracture, regardless of how simple it might be in its appearance, should be out of action for the rest of that year.

★★★

SOFT TISSUE INJURIES OF THE KNEE AND ANKLE



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We are entering the time of year when the hazards of the lower extremtiy seem to be more acute. Winter sports such as football, ice hockey, soccer and skiing present a particular risk to the lower extremity and particularly the knee and the ankle.

During the process of evolution the knee was not well designed and certainly not for the more popular winter sports. It is the articulation of the two and strongest bones in the body, namely, the femur and the tibit. A third bone, the patella, is the largest sesamoid bone in the body. The fibula, is not involved in the joint itself.

Because the femur is well rounded on its end and articulates with the tibia which is flat, it does not take much mechanical sense to realize that the strength of the joint does not come from the actual articulation of the bones. To compensate for this it is surrounded by large and strong muscles and strong ligaments. There are two menisci which are anchored on the tibia and aid in deepening the contour of the tibia for the bony femoral condyle. Motion of this joint is primarily flexion and extension although there is a small rotary component in the knee.

Briefly, the strength and stability about the knee is related to the anterior muscle group, the quadriceps, a posterior group, the hamstrings and the surrounding ligaments. While both muscle groups are quite important, the anterior or quadriceps groups are the most important particularly, the vastus medialis which has the function of maintaining the final 15 degrees of extension.

SLIDE—the ligaments are the medial and the mlateral ligaments; the anterior and posterior cruciate ligaments; and the posterior ligament which is actually a thickening of the ligament behind the knee.

These ligaments, particularly the medial collateral ligament and the anterior cruciate ligament, are the ones which are most often injured and they are quite often coupled with injuries to the medical meniscus around the knee.

Presented at Seminar on the Medical Aspects of Sports, August 14, 1967.

An injury of the extensor mechanism such as a direct blow or kick about the muscular attachment can cause varying degrees of effiusion and if a tendon is taut a complete rupture may occur.

This usually occurs just above the patella in Figure 1. It may occur also below the patella but this injury is not too common in football or other sports. We are ruling ut fractures f the patella which this shows.

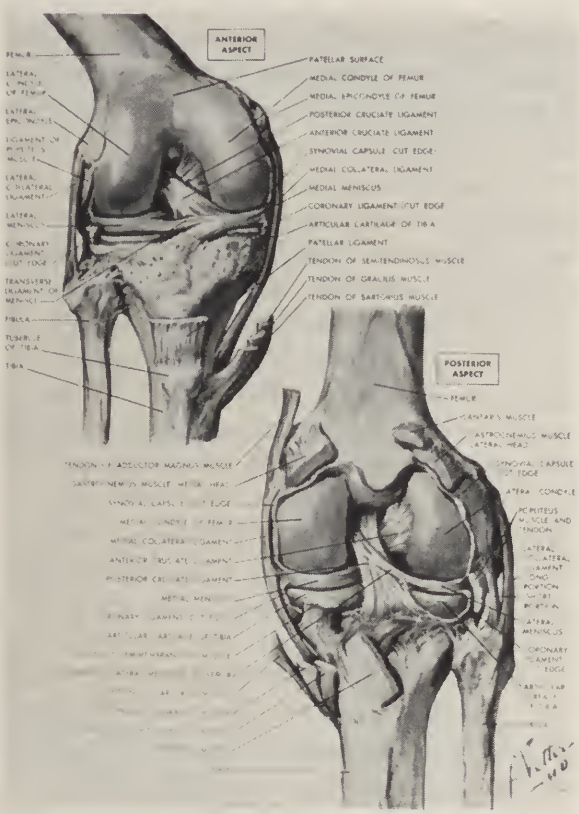


Figure 1

A simple hematoma is usually best treated by ice bags, compression dressing and quadiceps drill the active contraction and relaxation of the quadriceps. Larger hematomas may have to be aspirated. In later stages the hematoma is best treated by heat. A complete rupture of the quadriceps mechanism, must be treated by immediate surgery.

The patella is an integral part of the extensor mechanism and it may be dislocated by a direct

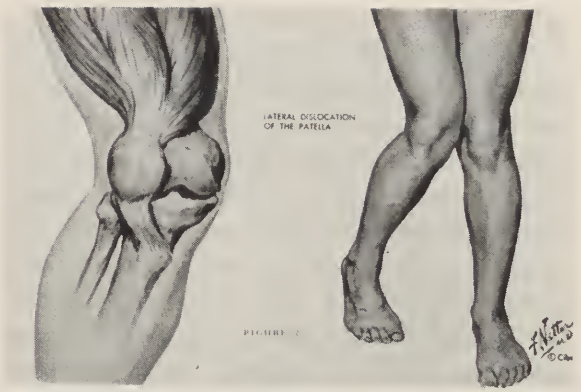


Figure 2

blow medially. The patella is dislocated laterally and this is the typical position as shown in Figure 2. Quite often a football player or an athlete will say, "My knee comes out of place," and diagnosis of a dislocated knee is made. To dislocate a knee would take a tremendous blow and I doubt if we would see this under game circumstances. It is a dangerous and devastating injury.

A dislocation of the patella would also be uncommon. What is actually being indicated —is usually an intrinsic problem in the joint itself, usually one of the menisci being damaged. When the patella is dislocated laterally one may forget a very important point. That is in order for the patella to be dislocated, the entire extensor mechanism on the medial side has to be completely torn. This does not mean that it needs immediate surgery because reduction and casting is adequate but this is a serious soft tissue injury. Reduction and immobilization is necessary. There is a tendency to experience a recurrence of this but it is not nearly as high as the tendency that recurs in a shoulder dislocation in the same age group.

Overlying the patella is the prepatellar bursa which is usually injured by direct blows. Knee pads are of minimal value in preventing this injury. This prepatellar bursitis is usually diagnosed because the swelling is anterior to the patella, under the skin. It is more commonly known as housemaid's knee, however it does occur on the football field.

The important point of this prepatellar bursitis is its differentiation from a true synovitis. the latter effusion is below the patella so that one can

Ballot the Patella ie. it seems to float.

The area is much more diffuse as opposed to the prepatellar bursitis which is usually localized and appears like a cyst on top of the patella.

Many injuries to the structures of the knee usually result in some form of synovitis. It is rapidly followed by a decreased quadriceps tone. In an acute injury, swelling must be differentiated between a simple acute synovitis and a hemarthrosis. The latter is usually the result of a severe injury and is usually a sign of complete ligamentous tear or an intra-articular fracture. It is quite rapid in onset and the knee becomes quite tense and, if untreated, quite warm.

If after an injury the swelling is rapidly manifested within the first few minutes to a half an hour then hemarthrosis, is the most likely diagnosis. In any case the knee should be aspirated. This gives important information not only to whether or not blood is present in the joint but more important if bone marrow is present in the blood.

The significance of bone marrow in the blood is indicative of an intra-articular fracture whether it is shown on the X-ray or not. In other words if the aspirated blood contains fatty particles of bone marrow, a fracture is present and X-rays many times miss these fractures complete 4%.

In addition, the aspiration not only gives valuable diagnostic aid but it also releases the pressure on the knee and aids in the patient becoming much more comfortable.

The most common ligament injured is the medial collateral ligament. Injury is caused by a forced abduction strain of the knee. In football it represents or results from a tackle when the knee is struck from the lateral or outer aspect. External rotation can rupture some of the anterior fibers of the liagment and it may be partially or completely torn. Complete tears are usually at the femoral attachment, next, near the joint line, and least common, at the tibia. Diagnosis is made from the mechanism of the injury and the points of tenderness along the ligaments. In a complete rupture the gap may be felt, although swelling may mask this. Stress X-rays are obtained by stabilizing the femur and applying an abduction force to the tibier. This may demonstrate an abnormal amount of separation of the medial joint line. It is best to use local anesthesia when attempting this test.

Minor sprains usually require only minimal immobilization and active quadriceps drill. Major sprains may herald a complex injury which may include the serious so-called unhappy triad. This is a rupture of the medial collateral ligament, the anterior cruciate igament, and a torn medial meniscus. If there is a complete tear of a major ligament then it is best handled by immediate sprains may herald a complex injury which surgery. Plaster immobilization following surgery is required and quadriceps exercises started as soon as possible.

Occasionally one sees an accumulation of calcium or even bone at the proximal or upper end of the medial collateral ligament. This most probably is due to a recurrent strain and is known as Pellegrini-Stieda disease. It is frequently a symptomatic, but, if after an acute injury there is joint tenderness it is treated as a soft tissue injury and protective weight-bearing, physical therapy, and quadriceps drill are usually satisfactory.

The cruciate ligaments, anterior and posterior, are usually ruptured after a marked displacement of the tibia on the femur and an isolated rupture of these ligaments is uncommon. The anterior cruciate is usually associated with injury to the medial collateral ligament, medial meniscus, or both. It may be avulsed after a forced hyperextension of the knee, and its rupture usually causes the forward gliding of the tibia on the femur when the knee is flexed at 90° and stabilizing the ankle. The tibia moved back and forth. If there is more than minimal motion it is known as a positive drawer sign, It is fraught with some difficulties becouse there is an intricate relationship between the curciate ligaments particularly the anterior, and the quadriceps mechanism and Quite often if a patient has poor quadriceps tone, there may be anterior laxity without ligament rupture. When both ligaments are ruptured there is a wide excursion in the anterior-posterior area.

In all injuries to the cruciate ligaments a he-

marthrosis is present. In former years it was felt that plaster immobilization was adequate for treatment, however. It is now generally accepted that these injuries should be treated by immediate surgery.

A sprain of the knee is caused by an abnormal stress on a ligament. Forced motion beyond the normal limit will result in some degree of injury to the ligament which is primarily involved. This motion may be in any direction. In a classic athletic injury of the knee the foot is fixed on the ground and the rotated inward and the tibia outward as the knee is forced. This stress is primarily to the medical collateral figament and the meniscus. When the foot is forced into external rotation, the stress is exerted against the medial collateral ligament. The superficial layer takes the strain first and as the outward rotation carries further more layers of the ligament are finally torn. The force then reaches deeper to the ligament around the medial meniscus which is then detached and finally it can be continued till it tears the anterior cruciate ligament. The injury may stop at any point in this progression of events.

In a similar manner, the reverse mechanism places stress on the lateral collateral ligaments, next the lateral cartilage, and again the anterior and posterior cruciate ligament. It might also be mentioned that a tear of the medial collateral ligament may or may not involve the posterior ligament of the knee which is also important in stability, but a tear of the lateral collateral ligament almost always carries a certain amount of tear of the posterior ligament and is quite a serious injury. Hyperextension, throws an initial tension on the posterior ligament of the joint followed by stress against the posterior cruciate and posterior part of the collateral ligaments.

In a mild ligament injury there has been some tear of the ligament fibers but the strength has not been particularly impaired. In this case prolonged treatment is not necessary and immediate application of a pressure dressing and an ice pack and possibly the use of ethyl chloride may be valuable. Local anesthesia may be injected into the area to reduce pain and spasm but once injected a player must not be allowed to resume playing that day.

Moderate ligament sprain means that the ligament has been partially torn. Its strength is impaired to a greater or lesser degree depending upon the number of fibers torn. There is usually more swelling and there may be a hematoma formation which can be aspirated. The use of ice, local compression, and plaster immobilization is necessary.

In severe ligamentous damage the immediate disability is usually severe. Local swelling is very rapid and there is usually a hemarthrosis and diffuse infiltration of blood throughout tissues about the knee. Stress X-rays show abnormal motion. Instability is the single confirmation finding. Increased abduction of the tibia with it in complete extension means that there has been a medial collateral and posterior ligament tear. This type of injury, should be treated with immeidate surgery.

Meniscus injuries. Figure 3. This injury frequently accompanies a ligamentous sprain. There is a medial and lateral meniscus. The medial meniscus is C-shaped and the lateral meniscus is shaped almost like an O. The attachment of the medial meniscus is firm to the tibia and the medial collateral ligament and allows little motion with the result that it is more easily torn. Injuries may occur anywhere along the meniscus, either longitudinally or transversely. A longitudinal tear may be large enough to allow the medial fragment to be displace medially and surround the femoral condyle causing the knee to lock and make complete extension impossible. If the tear is complete, the medial fragment is extruded into the intercondylar notch and complete extension is then possible.

If a tear is in the attachment of the ligament it heal but if it is in the substanc of the meniscus it will not. It is virtually impossible to determine whether there is a torn medial meniscus in an acute injury unless it is frankly locked. The lateral meniscus is much freer in the joint and particularly at the posterior portion, and is less vulnerable to an injury. Chronic overflexion which is the result of squatting for prolonged periods may cause damage to this meniscus. The ultimate treatment for a torn medial or lateral meniscus is usually excision.

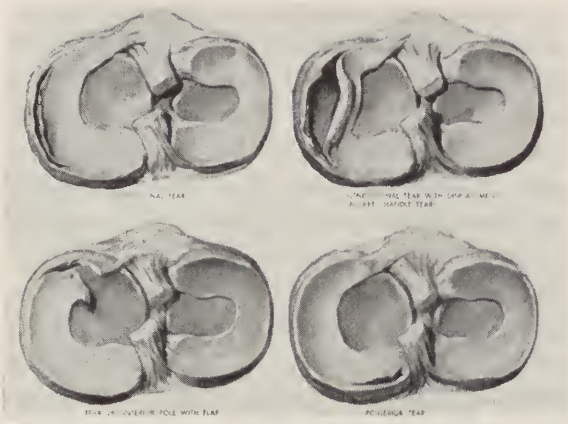


Figure 3

Injuries of the ankle constitute one of the most common conditions encountered in the injuries to an athlete. Many ankle injuries are treated too casually. Figure 4 shows the multiplicity of ligaments about the ankle and this, is the inner or medial aspect. The large ligament which attaches

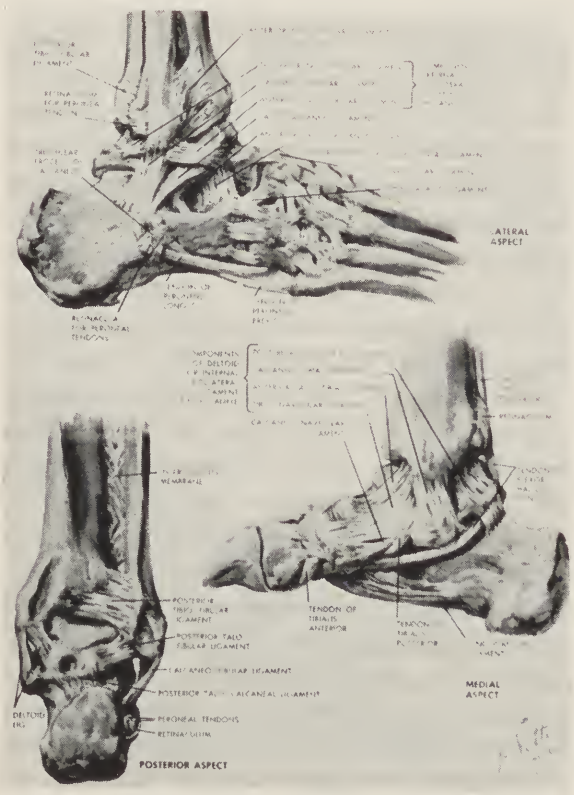


Figure 4

the tibia to the various bones in the foot goes under the collective name of the deltoid ligament. On the lateral or outer aspect there is a fan-shaped—three fan-shaped ligaments which also add stability to the outer aspect. In addition, back posteriorly, there are strong ligaments which go between the tibia and the fibula and these are both anterior and posterior. In addition there is also an interosseous membrane that is a thick tough scar-like tissue between the bones and at its very end it is even thickened more to form an interosseous ligament. And there are tendons which pass anteriorly and posteriorly.

The ankle may be thought of in terms of a ring. The bony structures of the tibia, fibula, talus and the oscalcis, and their ligamentous attachments complete the ring and in order to have any disruption of the ankle, at least two parts of the ring have to be broken. If any one part is broken, the ankle is quite stable, but if there are two parts broken instability results.

The ankle is a hinge joint with very little lateral motion. It is externally rotated about 15 to 20 degrees in dorsi—plantar flexion. The ankle actually only moves basically in two planes: dorsiflexion and plantar flexion. Inversion and eversion is from the subtalar joint. Functionally the ankle and subtalar joint can be considered as a universal joint. The ankle and subtalar joint strictly speaking is not, universal but functionally it can be moved in a complete circle.

Basically there are two motions in the foot: pronation and supination, pronation being an eversion type movement, supination being an inversion type movement. As such, these are the two basic types of injuries. The ligaments may also be stretched by forced plantar flexion or dorsiflexion but these are not particularly common.

The most common ankle joint injury a sprain due to a supination or inversion type of injury The sprain involves stretching of a ew fibers but with a normal amount of joint stability. Dislocation indicates major ligament damage and joint instability. Diagnosis must exclude a fracture.

Sprains of the lateral ligaments of the ankle vary in location and intensity with location being

of lesser importance. The severity of symptoms or signs influences the type of treatment. A mild sprain may be treated with strapping or an elastic support or injections with local anesthesia with or without Cortisone. Normal use is to be encouraged as soon as possible but, if injected, this does not mean returning to the game. The more severe sprain is often accompanied by a marked swelling and spasm. Treatment of the edema or swelling is most important and ice, initially, a compression dressing, preferably sponge rubber, rest, and elevation is best. This may or may not be followed by a short leg walking cast.

When the supination injury progresses the ligaments rupture and a temporary dislocation or subluxation results. It usually shows marked instability, and again stress X-rays are most helpful. The swelling is treated and, and this point, there seems to be a controversy as to what is best to do. Some feel that immediate repair is mandatory. Unfortunately, in this particular area, a fresh ligamentous injury about the ankle is very difficult to suture and I feel that probably casting for about six weeks or so is better.

The pronation or eversion types of injury are not very common. They are usually associated with other ligamentous injuries and fractures. Stress X-rays are helpful but occasionally a defect can be felt. The treatment is closed reduction and cast although surgery may be necessary particularly if the deltoid ligament, is entrapped between the malleolus and talus.

The muscles and the tendons may also be injured. The more common ones are a ruptured plantaris tendon, a rupture of the Achilles tendon, and subluxation of the peroneal tendon.

The plantaris tendon is really a vestigial type of tendon. It has a very small muscle belly, and it has a tendon which runs the entire length of the leg from the knee to the os calcis. It is not too frequently injured in football. It is more commonly injured by forced dorsiflexion of the foot it is frequently described as being kicked or the feeling of a golf ball striking the back of the calf. This usually is a rupture of the plantaris tendon. It is usually more confused on the football field or in contact sports with an actual tear or partial rupture of the muscle belly if the gastrocnemius.

A torn Achilles tendon is not particularly common but does occur and can end a football career. Immediate repair best.

Subluxation of the peroneal tendon is usually related to ligamentous injury about the outer side of the ankle. This is best treated by a cast and after the cast has been removed the patient should be encouraged to do muscle strengthing exercises. Many times this will be satisfactory enough to allow return to their former sports without too much difficulty. In rare cases surgery is necessary.

The most important part, of course, is prevention. Good conditioning and good equipment are fundamental. Strapping a normal knee is not necessary although it may be of limited benefit in a knee that has already been injured.

Strapping of the ankle however, should be mandatory not only for games but for practice sessions.

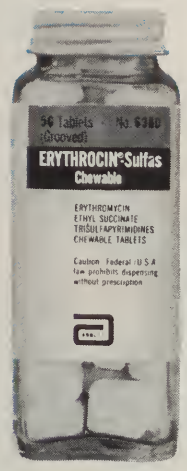
I have tried to outline some of the more common injuries about the knee and ankle. Prevention is the key word but if an injury does occur, accurate diagnosis and early treatment must be carried out.

Slides, courtesy of CIBA *"Symposium."*



Perhaps there have been times when you wanted to prescribe erythromycin and triple sulfas for little patients. Now you can—with a choice of two new fine-tasting pediatric forms.

New–Two Pediatric Forms of Erythromycin and Triple Sulfas





ERYTHROCIN®-SULFAS Chewable (Erythromycin ethyl succinate-trisulfapyrimidines chewable tablet)

In clinical trials[1,2], this orange-flavored tablet was given to 55 patients, aged four months to 18 years.

Diagnoses (multiple in some cases) represented a cross section of bacterial infections commonly seen in pediatric office practice.

Therapy was given from three to 12 days, with an average of six days.

Of the 55 patients, 30 were reported cured within 72 hours, while 22 showed partial recovery within the same time, and subsequent clinical cure.

A clinical cure rate of 94.5%

ERYTHROCIN®-SULFAS Granules (Erythromycin ethyl succinate-trisulfapyrimidines granules for oral suspension)

87 patients were treated[1,2]—all children, ages four months to 15 years.

The diagnoses were multiple in some cases and were chiefly bacterial infections of the respiratory tract.

Dosage was maintained from three to 10 days; average treatment was five days. All of the ill children accepted the orange-flavored suspension favorably.

53 were clinically cured within 72 hours, while 32 showed partial relief within the same time, and subsequent clinical cure.

701358

A clinical cure rate of 97.7%

1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

ABBOTT

Brief Summary on next page

ERYTHROCIN®-SULFAS
Brief Summary

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or newborn infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. of each of sulfadiazine, sulfamerazine and sulfamethazine.

701358

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The Alcazar
4 BEAUTIFULLY DECORATED BANQUET ROOMS
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A Building Block approach to treating hypertension

With these three therapeutic building blocks you can create a once-a-day regimen to fit almost any degree of hypertension. See the following pages for details . . .



Consider starting your hypertensives on this basic thiazide

A single daily dose of Enduron provides sodium excretion around the clock

Enduron is a true 24-hour single-dose thiazide. Its sodium excretion is not squeezed into an abrupt peak during the first several hours. It is well-sustained in a plateau-like effect—with little reduction for the first 12 hours, and decline thereafter only gradual.

Potassium loss, by contrast, is low. It reaches an early minor peak, then subsides rapidly. Moreover, since dosage is but once a day, there is but one daily peak of potassium loss. As with all thiazides, however, dietary potassium supplementation should also be considered, especially in long or intensive therapy.

Use Enduron as an ideal starting therapy in mild hypertension. Use it too, as a basic therapeutic building block with which other agents can be joined, for managing your more resistant hypertensives.

Once a day, every day

ENDURON®
METHYCLOTHIAZIDE



DAILY DOSAGE RANGE	Minimum	Usual	Intermediate	Maximum
	2.5 mg. tablet	5 mg. tablet	7.5 mg.	10 mg.

See Brief Summary on final page of advertisement.

To build added response, shift to Enduronyl

The deserpidine component adds enhanced antihypertensive activity

The rauwolfia component of Enduronyl is deserpidine (Harmonyl®), a purified crystalline alkaloid supplied only by Abbott. It augments Enduron with its own antihypertensive and tranquilizing action.

Thus the combined clinical effect of these two therapeutic building blocks in Enduronyl is greater than can ordinarily be achieved with either alone.

To add flexibility, Enduronyl comes in two strengths: regular and Forte. Both provide 5 mg. of Enduron. The variation is where most helpful: in the deserpidine. The tablets are scored, and give a surprisingly wide and economical choice of once-a-day doses (see below).

Choose Enduronyl for your patients in the broad range of mild to moderate hypertension. Patient acceptance is excellent!



Once a day, every day

ENDURONYL®

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.25 MG.

ENDURONYL FORTE

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.5 MG.

	Minimum	Usual	Intermediate	Maximum
DAILY DOSAGE RANGE	2.5 mg. methyclothiazide 0.125 mg. deserpidine	5 mg. methyclothiazide 0.25 mg. deserpidine	7.5 mg. methyclothiazide 0.375 mg. deserpidine	10 mg. methyclothiazide 0.5 mg. deserpidine
DAILY DOSAGE RANGE	2.5 mg. methyclothiazide 0.25 mg. deserpidine	5 mg. methyclothiazide 0.5 mg. deserpidine	7.5 mg. methyclothiazide 0.75 mg. deserpidine	10 mg. methyclothiazide 1 mg. deserpidine

See Brief Summary on final page of advertisement.

707075-R

Eutonyl affords a different kind of basic therapy for moderate to severe cases

Effect tied to reduced peripheral vascular resistance; no central depressant action

Eutonyl is a unique nonhydrazine agent. It is reported to act by reducing peripheral vascular resistance.[1,2]

In clinical trials, significant reductions in mean blood pressure were seen in 84% of patients studied—all were moderate to severe cases. Eutonyl lowers diastolic in proportion to systolic, and in about half of the cases studied, reductions in the sitting and recumbent positions were nearly as great as in the standing position.

Most important: There is no central depressant action. In fact, some patients reported an *increased* sense of well being.

Here, then, is a highly effective *basic treatment* for moderate to severe cases—and one that will not hamper your patient with lethargy or drowsiness while on treatment.

Once a day, every day

EUTONYL®
PARGYLINE HYDROCHLORIDE



DAILY DOSAGE RANGE	Minimum	Usual starting	Intermediate	Maximum
	10 mg. tablet	25 mg. tablet	50 mg. tablet or as needed	200 mg.

1. Brest, A. N., et al., Cardiac and Renal Hemodynamic Response to Pargyline, Ann. N. Y. Acad. Sci., 107-1016, 1963.
2. Winsor, T., Pargyline Hydrochloride, Hypertension, Urinary Tryptamine, and Vascular Reflexes, Geriatrics, 19:598, Aug., 1964.

See Brief Summary on final page of advertisement.

Eutron adds thiazide for enhanced therapy with milder side effects

Only a 7/4 mm. span between standing and recumbent pressures in clinical trials—reduced chance of orthostatic hypotension

The combining of Eutonyl and Enduron in Eutron permits a significantly greater antihypertensive effect than with either agent used alone. This in turn may allow therapeutic success with lesser dosage—and correspondingly milder side effects.

A significant finding in clinical trials was the drug's action in lowering blood pressure to *nearly equal levels in all body positions.* Total average spread between standing and recumbent readings (after treatment) was only 7/4 mm. Hg.

Thus, in your moderate to severe cases, Eutron affords a usually smooth course of therapy, often with reduced likelihood of orthostatic effects. (The usual precautions against rising suddenly, of course, will always apply.) And, because of the thiazide component, Eutron may be used in the presence of congestive heart failure.



Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 MG.
WITH METHYCLOTHIAZIDE 5 MG.

DAILY DOSAGE RANGE	Minimum	Usual starting	Intermediate	Maximum
	12.5 mg. pargyline hydrochloride and 2.5 mg. methyclothiazide	25 mg. pargyline hydrochloride and 5 mg. methyclothiazide	37.5 mg. pargyline hydrochloride and 7.5 mg. methyclothiazide	50 mg. pargyline hydrochloride and 10 mg. methyclothiazide

See Brief Summary on final page of advertisement.

TM—Trademark

707075-R

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Enduron is used to control edema and mild to moderate hypertension; also used with other drugs for hypertension. Enduronyl is used in mild to moderately severe hypertension; when used with Enduronyl, more potent agents can be given at reduced dosage to minimize undesirable side effects.

Contraindications: Neither Enduron nor Enduronyl should be used in severe renal disease (except nephrosis) or shutdown; in severe hepatic disease or impending hepatic coma; in patients sensitive to thiazides. Hepatic coma has been reported as a result of hypokalemia in patients receiving thiazides.

Enduronyl is contraindicated in patients with severe mental depression and suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity reactions in patients with a history of allergy or asthma. If added potassium intake is indicated, dietary supplementation is recommended. Enteric-coated potassium tablets should be reserved for cautious use only when adequate dietary supplementation is not practical because those tablets may induce serious or fatal small bowel lesions consisting of stenosis with or without ulceration. These small bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs.

Precautions: Use thiazides with caution in severe renal dysfunction, impaired hepatic function, or progressive liver disease. In surgical patients, thiazides may reduce the response to vasopressors and increase the response to tubocurarine. Use thiazides with caution in pregnancy (bone marrow depression, thrombocytopenia, or altered carbohydrate metabolism have been reported in certain newborn infants). Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. Antihypertensive response may be enhanced following sympathectomy.

Use Enduronyl with caution in patients with a history of peptic ulcer, as rauwolfias may increase gastric secretion. Discontinue at the first sign of mental depression. Rauwolfia alkaloids may increase hypotensive effects of surgery or anesthesia, and should be discontinued two weeks prior. They also lower the convulsive threshold and shorten seizure latency. In epilepsy, dosage adjustment of anticonvulsant medication may be necessary. Alcohol, barbiturates, or narcotics may potentiate action of deserpidine.

Adverse Reactions: During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). All patients should be observed for signs of hyponatremia ("low-salt" syndrome). Reported thiazide reactions include: anorexia, nausea, vomiting, diarrhea, headache, skin rash, dizziness, paresthesia, weakness, photosensitivity, jaundice, and pancreatitis.

Reported rauwolfia reactions include: nasal stuffiness, nausea, weight gain, diarrhea, aggravation of peptic ulcer, epistaxis, skin eruption, and reduction of libido and potency. Excessive drowsiness, fatigue, weakness, and nightmares may signal early signs of mental depression.

EUTONYL® | EUTRON™

PARGYLINE HYDROCHLORIDE

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications: For treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. Not recommended for patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone. It is desirable to establish the dosage of Eutron by administering component drugs separately.

TM-Trademark.

Contraindications: Pheochromocytoma, advanced renal disease, increasing renal dysfunction, paranoid schizophrenia and hyperthyroidism. Hepatic coma has been reported as consequence of hypokalemia with thiazide therapy. Until further experience is gained not recommended for patients with malignant hypertension, children under 12, or pregnant patients.

Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. 2 week interval should separate therapy and use of these agents.

Methyclothiazide is contraindicated in patients with known sensitivity to thiazides.

Warnings: Pargyline hydrochloride is a monoamine oxidase inhibitor. Warn patients against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When indicated, alcohol, narcotics (meperidine should be avoided), antihistamines, barbiturates, chloral hydrate, and other hypnotics, sedatives, tranquilizers, or caffeine, may be used cautiously in reduced dosage. In emergency surgery ¼ to ⅓ the usual dose of narcotics, analgesics, and other premedications should be used avoiding parenteral administration where possible. Carefully adjust dose of anesthetics to response of patient. Withdraw pargyline two weeks before elective surgery.

Warn patients about the possibility of postural hypotension. Those with angina or coronary artery disease should not increase physical activity with an improvement in well being. Pargyline may lower blood sugar.

Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions consisting of stenosis with or without ulceration. These small-bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs. These products contain no added potassium salts and if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical. In patients with a history of allergy or asthma the possibility of sensitivity reactions should be considered.

Precautions: Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields and fundi. Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. In surgical patients thiazides may reduce response to vasopressors and increase response to tubocurarine.

Adverse Reactions: Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extrapyramidal symptoms have been reported in a few patients with reduced cardiac reserve.

During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). Observe all patients for signs of hyponatremia ("low salt" syndrome).

Reported thiazide reactions also include anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, and pancreatitis. Nocturia has been observed with the combination.

709075R

ABBOTT

A breakthrough in the control of pain

Talwin®

brand of

pentazocine

(as lactate)

**a potent injectable non-narcotic—
may be used in place of morphine
and other narcotic analgesics**



A breakthrough in the control of pain

Talwin®

brand of

pentazocine

(as lactate)

a potent injectable non-narcotic—may be used in place of morphine and other narcotic analgesics

Talwin 30 mg. relieves pain usually as quickly and effectively as morphine 10 mg.*

whatever the intensity of the pain

whatever the cause of the pain

whatever the site† of the pain

whatever the chronicity of the pain

whatever the age†† of the patient

without the liability of narcotics

without the development of tolerance on prolonged use

with less risk of severe respiratory depression than with morphine

with less constipation

with less urinary retention

Clinical experience of more than 150 investigators with over 12,000 patients given varying dosages of Talwin shows that this potent injectable analgesic is not a narcotic.

Talwin has less risk of severe respiratory depression, urinary retention, and constipation than morphine—a great boon for postsurgical patients.

Talwin produces less nausea, vomiting and diaphoresis than meperidine.

Constipation and urinary retention are seldom a problem with Talwin.

Very rarely do hallucinations or disorientation occur (0.1% each).

No significant hepatic, renal, hematopoietic or neurologic disturbances have been reported.

Talwin is well tolerated even by the aged or very ill patients.

Used during active labor, its tolerance by the mother and newborn is comparable to meperidine's. As with all new drugs, Talwin should be used with caution in pregnant women and in women delivering premature infants.

Tolerance to the analgesic effect of Talwin has not developed with prolonged use.

Talwin gives significant relief of pain in from 15 to 20 minutes following I.M. or S.C. injection.

Talwin relieves pain usually for 3 hours or longer with a single injection; however, the duration may sometimes be less than with morphine.

*Its duration of action may sometimes be less than that of morphine.

†Should not be used for patients with increased intracranial pressure, head injury or pathologic brain conditions.

††Until sufficient experience is gained, Talwin should not be administered to children under 12 years of

86 per cent of medical and surgical patients obtained excellent to good relief with Talwin 30 mg. administered

Talwin

brand of pentazocine (as lactate)

used for pain of all types

Talwin has a wide range of usefulness in surgery

Types of surgical use	Number of patients	Efficacy				
		% Exc.	% Good	Exc. + Good	% Fair	% Poor
• Preoperative	118	31	52	83%	15	2
• Postoperative	914	58	28	86%	8	6
• Pre- and postoperative	12	75	17	92%	0	8
• Minor surgery	33	30	39	69%	0	31*
• Traumatic	14	64	29	93%	7	0
• Dental	33	67	24	91%	3	6
Total patients.....1124						

Efficacy of 30 mg. Talwin I.M. and S.C. as related to types of surgical use in a cooperative study

Data in files of Department of Medical Research, Winthrop Laboratories.

*High incidence of poor results in minor surgery is due primarily to one study involving change of burn dressings in children; 9 of 19 patients obtained poor results with dose used.

Talwin relieves all types of pain in acute and chronic medical disorders

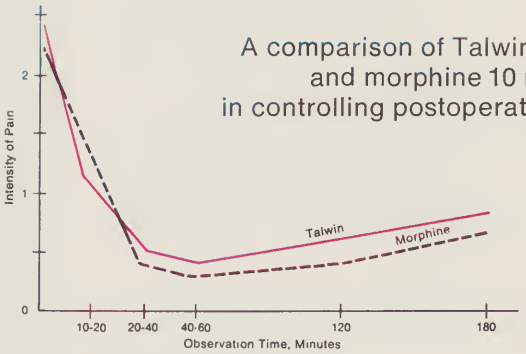
Type of medical pain	Number of patients	Percentage of relief				
		Excellent	Good	Exc. + Good	Fair	Poor
• Malignancy, pain in	161	44	37	81%	8	11
• Orthopedic; see also "Arthritis"	111	53	38	91%	5	4
• Cardiovascular pain; see also "Miscellaneous medical"	96	59	27	86%	6	7
• Genitourinary pain	83	42	33	75%	16	10
• Arthritis	76	33	51	84%	12	4
• Gynecologic pain	35	57	34	91%	6	3
• Cephalalgia	21	45	41	86%	9	5
• Gastrointestinal pain	19	89	5	94%	0	5
• Chest, including • Pleurisy • Pulmonary embolism and infarct • Lung abscess	12	83	17	100%	0	0
• Miscellaneous medical, including • Peripheral vascular disease • Thrombophlebitis • Cervical root pain • Facial neuralgia • Syringomyelia • Burns	108	50	39	89%	9	2
Total patients.....722						

Efficacy of 30 mg. Talwin I.M. and S.C. as related to types of medical pain in a cooperative study

Data in files of Department of Medical Research, Winthrop Laboratories.

See next page for additional product information

Talwin relieves pain as quickly as morphine



A comparison of Talwin 30 mg. and morphine 10 mg. I.M. in controlling postoperative pain*

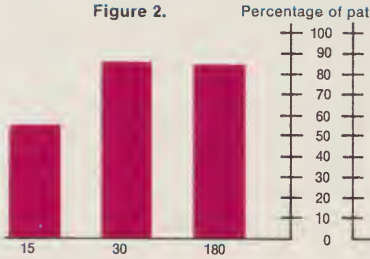
Figure 1.

Talwin 30 mg. proved equivalent to morphine 10 mg. in overall analgesic efficacy. During the early post-medication period (up to 40 minutes after drug injection), Talwin was superior in effect to morphine.

After observation periods ranging from 40 to 180 minutes there was no difference between the drugs in their effect on intensity. There were 141 and 119 complete patient records for Talwin and morphine, respectively, in this double-blind study. Other clinical investigators, studying duration, state that relief with Talwin may be obtained for up to three hours or longer, a period sometimes less than morphine's.

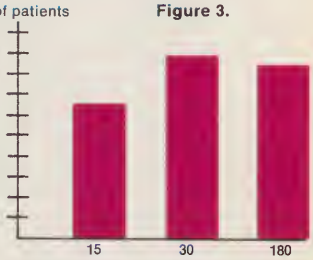
Talwin is as effective for severe pain (Fig. 2)† as for moderate pain (Fig. 3)†

Figure 2.



Per cent excellent to good relief of severe pain obtained with 30 mg. Talwin in 218 postoperative patients

Figure 3.



Per cent excellent to good relief of moderate pain obtained with 30 mg. Talwin in 203 postoperative patients

Talwin does not require a narcotics prescription or narcotics records

The World Health Organization Expert Committee on Dependence-Producing Drugs concluded that "...there was no need at this time for narcotics control of pentazocine [Talwin] internationally or nationally."‡

*Storer, E. H.: Data in the files of the Sterling-Winthrop Research Institute.

†Cooperative study, data in the files of the Department of Medical Research, Winthrop Laboratories.

‡*World Health Organization Technical Report Series*, No. 343, 1966, p. 6.

A breakthrough in the control of pain

Talwin®

brand of

pentazocine

(as lactate)

a potent injectable non-narcotic — may be used in place of morphine and other narcotic analgesics

Contraindications: *Increased Intracranial Pressure, Head Injury, or Pathologic Brain Conditions in which clouding of sensorium is undesirable.* Talwin (brand of pentazocine) should not be administered in these cases, since drug-induced sedation, dizziness, nausea, or respiratory depression could be misleading.

Precautions: *Pregnancy.* No teratogenic or embryotoxic effects attributable to the use of Talwin have been seen in extensive reproductive studies in animals; however, like all new drugs, Talwin should be given with caution to pregnant women. A large number of patients in labor have received the drug with no adverse reactions other than those that occur with commonly used strong analgesics. However, as with other strong analgesics, Talwin should be used with caution in women delivering premature infants.

Ambulatory Patients. Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

Certain Respiratory Conditions. The possibility that Talwin (brand of pentazocine) may cause respiratory depression should be considered in treatment of patients with bronchial asthma. Talwin should be administered only with caution and in low dosage to patients with respiratory depression (e.g., from other medication, uremia, or severe infection), obstructive respiratory conditions, or cyanosis.

Patients Dependent on Narcotics. Because Talwin is a narcotic-antagonist, patients dependent on narcotics and receiving Talwin may occasionally experience certain withdrawal symptoms. Talwin should be given with special caution to such patients. It has been observed that some patients previously given narcotic-analgesics for one month or longer had mild withdrawal symptoms when the drug was replaced with the analgesic, Talwin. After a short period of adjustment the subjects were usually able and willing to continue taking Talwin, and relief of pain was satisfactory.

Nonaddicted Patients Receiving Narcotics. Symptoms believed to be indicative of antagonism to the opiate may be observed rarely with administration of Talwin to patients receiving opiates for a short time. Intolerance or untoward reactions are seldom observed after administration of Talwin to patients who have received single doses or who have had limited exposure to narcotics.

Impaired Renal or Hepatic Function. Although laboratory tests have not indicated that Talwin (brand of pentazocine) causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment. Extensive liver disease appears to predispose to greater side effects (e.g., marked apprehension, anxiety, dizziness, sleepiness) from the usual clinical dose, and may be the result of decreased metabolism of the drug by the liver.

Myocardial Infarction. As with all drugs, Talwin (brand of pentazocine) should be used with caution in patients with myocardial infarction who have nausea or vomiting.

Biliary Surgery. Until further experience is gained with the effects of Talwin on the sphincter of Oddi, the drug should be used with caution in patients about to undergo surgery of the biliary tract.

Adverse Effects: Talwin is relatively free from the undesirable side effects associated with morphine, such as constipation, urinary retention, or severe respiratory depression. Furthermore, Talwin produces less nausea, vomiting, and diaphoresis than meperidine.

In over 12,000 patients who received Talwin intramuscularly, subcutaneously, or intravenously, nausea, the most frequent adverse effect, occurred in approximately 5.0 per cent. In decreasing order of occurrence were vertigo, dizziness or lightheadedness; vomiting; and euphoria. Respiratory depression was reported as an adverse reaction in 1.0 per cent.

The incidence of each of the other adverse effects was well below 1.0 per cent: constipation, circulatory depression, diaphoresis, urinary retention, alteration in mood (nervousness, apprehension, depression, floating feeling), hypertension, sting on injection, headache, dry mouth, flushed skin including plethora, altered uterine contractions during labor, dermatitis including pruritus, dreams, paresthesia, and dyspnea occurred rarely after administration of Talwin (brand of pentazocine). Furthermore, each of the following adverse reactions occurred in less than 0.1 per cent: tachycardia, visual disturbance (blurred vision, diplopia and nystagmus), hallucinations, disorientation, weakness or faintness, muscle tremor, chills, allergic reactions including edema of the face, taste alteration, insomnia, diarrhea, cramps, and miosis; laryngospasm in one patient.

Talwin has not produced severe respiratory embarrassment in adults (never apnea), even with large amounts. A small number of newborn infants whose mothers received Talwin during labor had transient apnea. The incidence of temporary diminution in the rate or strength of uterine contractions is low after administration of Talwin, similar to that following meperidine hydrochloride. (In reporting no interference with normal labor in patients receiving Talwin, one investigator further stated that the drug may increase uterine activity.) Generally, no significant fetal heart rate change occurs.

Laboratory tests of blood and of liver and kidney functions have revealed no significant abnormalities. A minimum and probably insignificant increase in the per cent of eosinophils in peripheral blood counts and bone marrow occurred occasionally.

Talwin is well tolerated by patients with diabetes mellitus, and no changes in insulin requirements have been observed.

Dosage and Administration: *Adults, Excluding Patients in Labor.* Average recommended single parenteral dose is 30 mg., by intramuscular, subcutaneous, or intravenous route; may be repeated every three to four hours. Pain has been relieved in most patients with not more than three doses daily. Infrequently, selected patients have received single doses as high as 60 mg.

Patients in Labor. A single, intramuscular 30 mg. dose has been most commonly administered. An intravenous 20 mg. dose has given adequate pain relief to some patients in labor when contractions become regular, and this dose may be given two or three times at two- to three-hour intervals, as needed.

Children Under 12 Years of Age. Since clinical experience in children under twelve years of age is limited, the use of Talwin (brand of pentazocine) in this age group is not recommended.

Duration of Therapy. Patients with chronic pain who received Talwin for prolonged periods (e.g., over 300 days) experienced no withdrawal symptoms even when administration was stopped abruptly; furthermore, there was no tolerance to the analgesic effect.

CAUTION. Talwin should not be mixed in the same syringe with soluble barbiturates because precipitation will occur.

Treatment of Overdosage or Respiratory Depression. Talwin has not produced apnea or severe respiratory embarrassment in adults, even in large doses. Occasionally, however, moderate respiratory depression may occur. Means of maintaining proper oxygenation should be available in case of overdosage or respiratory depression, and methylphenidate (Ritalin®) should be administered parenterally. The usual narcotic-antagonists, such as nalorphine, are not effective respiratory stimulants for depression due to Talwin.

How Supplied: Ampuls of 1 ml., containing Talwin® (pentazocine) as lactate equivalent to 30 mg. base and 2.8 mg. sodium chloride, in Water for Injection. **Boxes of 10, 25, and 100.**

Multiple dose vials of 10 ml., each 1 ml. containing Talwin® (pentazocine) as lactate equivalent to 30 mg. base, 2 mg. acetone sodium bisulfite, 1.5 mg. sodium chloride, and 1 mg. methylparaben as preservative, in Water for Injection. **Boxes of 1.**

The pH of Talwin solutions is adjusted between 4 and 5 with lactic acid and sodium hydroxide.

Winthrop

Winthrop Laboratories, New York, N.Y. 10016

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New view of an oral contraceptive at work

Although suppression of ovulation remains the primary mode of action of oral contraceptives, newer knowledge indicates that products like Norinyl-1—a combination of both low-dosage progestogen and estrogen for the full treatment cycle—may provide multiple action that helps explain their unexcelled record of contraceptive effectiveness. This report explores the possible secondary protective mechanisms offered by combined hormonal administration.

Accumulating evidence has indicated that sparse, highly viscous cervical mucus has a possible adverse effect on the motility and survival of spermatozoa.

The estrogen-opposing progestational ingredient of Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.) changes the usual mid-cycle picture of a thin, watery cervical mucus. The result—a built-in barrier that appears to inhibit sperm from reaching the ovum should one be released. The inset in the adjoining photograph shows immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

See last page for contraindications, precautions, side effects and dosage.

How the estrogen-opposing action of Norinyl-1 creates cervical mucus that may be hostile to sperm penetration

Normally, estrogen activity during the fertile midcycle stimulates the production of a profuse and watery cervical mucus that permits maximum sperm motility and promotes penetration.

But what happens when Norinyl-1 is administered? Its potent progestogen, norethindrone, opposes estrogen stimulation of cervical mucus. Consequently, the amount of mucus decreases and its viscosity increases. This results in a sparse but thick mucus barrier that appears to diminish the vitality of the sperm and to impair its powers of penetration.

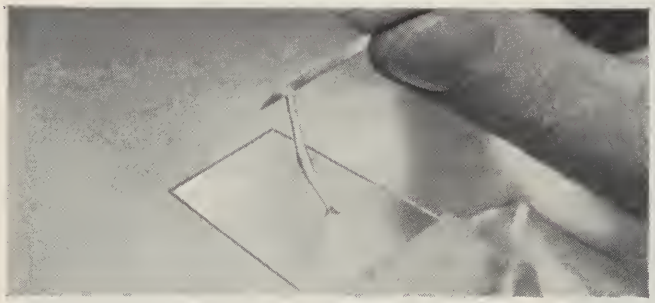
The role of viscous cervical mucus as a secondary action of Norinyl-1

In a report on 89 patients taking this medication,* cervical mucus obtained from cycle day 5 to cycle day 29 appeared scant and thick and exhibited little or no Spinnbarkeit.

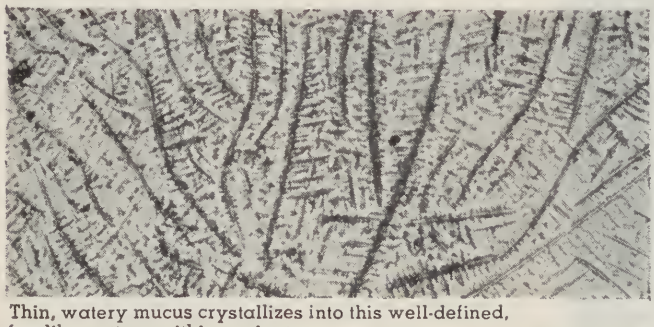
In the opinion of this investigator, the effect on cervical mucus may be sufficient to prevent conception.

*Cohen, M. R.: Symposium: Mechanisms of Action of Low Dosage Oral Contraceptive, Yale University Medical Center, New Haven, Conn., April 6, 1967.

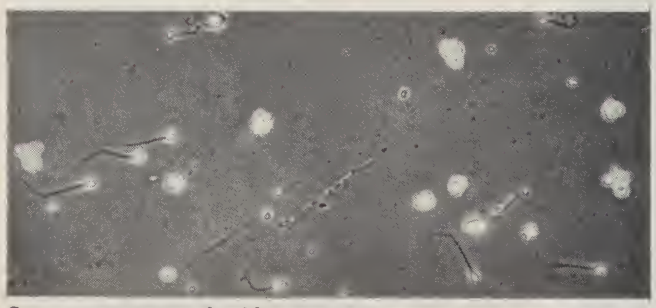
Normal cervical mucus at midcycle in untreated patient is known to permit sperm motility... promote sperm penetration.



Cervical mucus is thin and watery with a stretchability (Spinnbarkeit) of 15 to 20 cm.



Thin, watery mucus crystallizes into this well-defined, fernlike pattern within a minute.

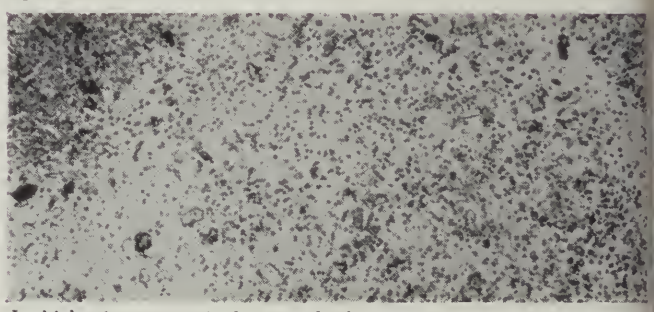


Spermatozoa appear healthy, are active and freemoving.

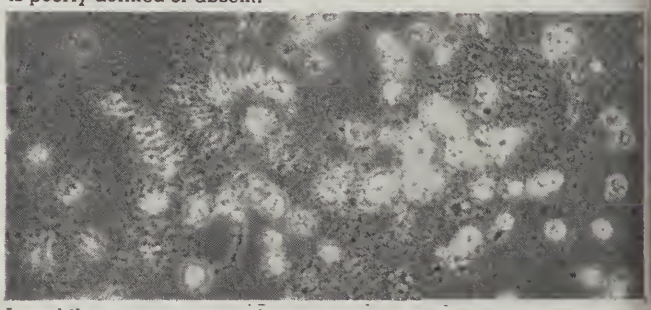
Viscous cervical mucus at midcycle produced by Norinyl-1 appears to impair sperm vitality... inhibit penetration.



Cervical mucus is scanty, thick and viscous. Spinnbarkeit is 1 cm. or less.



In thick, viscous cervical mucus the fern pattern is poorly defined or absent.



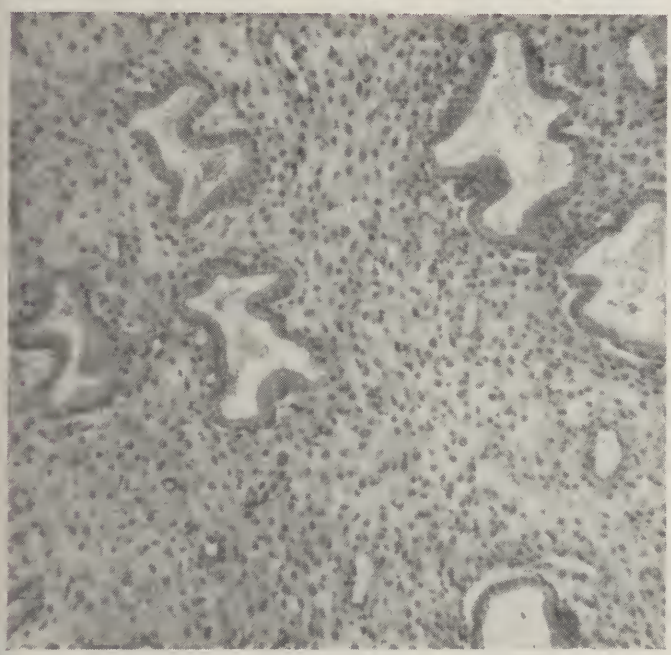
Immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

How Norinyl-1 alters normal endometrial responses—another possible protective mechanism

Let us suppose that an ovum is released—as occurs in an occasional, rare case—and somehow a sperm succeeds in penetrating the cervical mucus barrier. Should this come about, one additional action of Norinyl-1 may protect the patient from unwanted pregnancy. The theory is that progestogen intake makes endometrial tissue unreceptive to implantation.

Endometrium of untreated patient

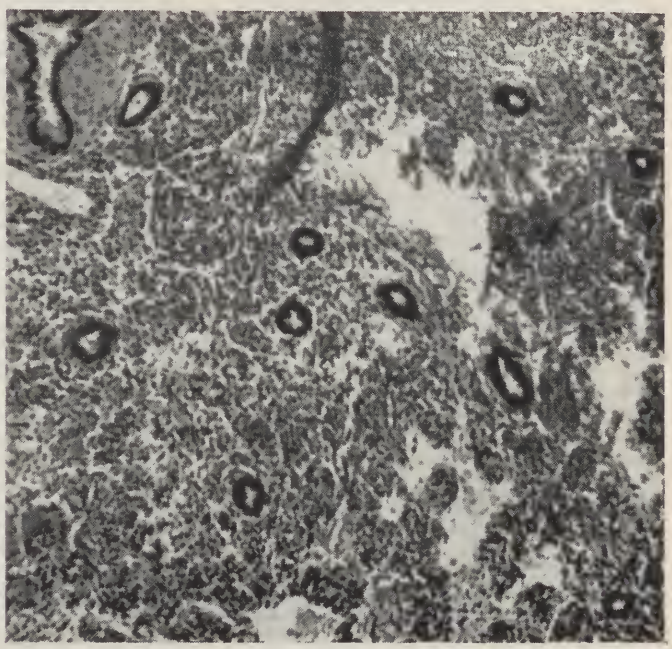




Normally, the endometrium progresses through a proliferative phase stimulated by estrogen and a secretory phase stimulated by progesterone. During the secretory phase the endometrium is receptive to the fertilized ovum.

Endometrium produced by Norinyl-1





When Norinyl-1 is administered its progestogen component—norethindrone—accelerates the secretory phase and suppresses glandular and vascular development.

See last page for contraindications, precautions, side effects and dosage.

new Norinyl-1® tablets

(norethindrone 1mg. c mestranol 0.05mg.)

for multiple contraceptive action

effective fertility control on half the previous dosage

maintains ratio of the established norethindrone/mestranol combination

lower cost

new Norinyl®-1 tablets

(norethindrone 1mg. c̄ mestranol 0.05mg.)

Reduction of oral contraceptive dosage to lowest effective levels has become a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now available in a new strength in which *both* norethindrone and mestranol are reduced 50 percent. Studies show that Norinyl-1 achieves fertility control with only 1.05 mg. of combined progestogen and estrogen per tablet.

Norethindrone was first reported for use as a progestational agent in human beings in 1955. Norethindrone 2 mg. with mestranol 0.1 mg., as an oral contraceptive, is currently in use by over 2,000,000 women. Clinical experience now establishes that Norinyl-1 also amply meets the criteria of reliability and safety.*

*Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965.

PRESCRIBING INFORMATION

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of Norinyl-1 in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with Norinyl-1. Therefore, if such tests are abnormal in a patient taking Norinyl-1, it is recommended that they be repeated after the drug has been withdrawn for 2 months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibroids may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac, or renal dysfunction, require careful observation. 5. Although a cause and effect relationship has not been established, Norinyl-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, as in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged Norinyl-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Norinyl-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. A cause and effect relationship has not been demonstrated. 11. Because of the effects of estrogens on epiphyseal closure, Norinyl-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask the onset of the climacteric. 13. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma, breast changes (tenderness, enlargement and secretion), loss of scalp hair, change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, erythema multiforme, erythema nodosum, hemorrhagic eruption, migraine, rash (allergic), itching, rise in blood pressure in susceptible individuals, mental depression.

The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has not been established: thrombophlebitis, pulmonary embolism, neurooocular lesions.

The following laboratory results may be altered by the use of oral contraceptives: increased bromsulphalein retention and other hepatic function tests, coagulation tests (increase in prothrombin, factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metapyrone test, pregnanediol determination.

Other side effects reported to have occurred in association with use of this drug are dizziness, hirsutism, pains in legs, back, chest and abdomen, dysuria, drowsiness, vaginal discharge, libido increased and decreased, eruptions, hypermenorrhea, hypomenorrhea, increased appetite, G.U. infections, varicose veins, abdominal fullness, acne, headache, nervousness, allergies, blurred vision, pain in eyes, and itching in eyes. *For complete clinical data, see package insert.*

Dosage and Administration: 1. One tablet of Norinyl-1 is administered orally for 20 days beginning on day 5 of the menstrual cycle. (Count day 1 of the cycle as the first day of menstrual bleeding.) Repeat this dosage schedule for each cycle. 2. If no menstrual period occurs after a cycle of treatment (20 tablets) in which patient adhered to the schedule, the patient must be instructed to resume taking the Norinyl-1 tablets 7 days after the previous 20-day course was completed. For example, if the last pill of a previous cycle had been taken on a Sunday, then a new cycle of treatment should begin on the following Sunday. 3. In the postpartum woman, it is recommended that the first cycle of treatment should begin on day 5 of the first menstrual cycle. However, Norinyl-1 should not be administered during lactation.

Availability: Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.)—Dispensers of 20 and 60 and bottles of 250 tablets.

norethindrone — an original steroid from

SYNTEX LABORATORIES INC., PALO ALTO, CALIF.

SEMIANNUAL MEETING
September 8, 1967

REPORTS

To the House of Delegates

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Mr. President and Members of the House of Delegates:

Your three delegates and alternate delegates attended all of the House sessions of the American Medical Association House of Delegates meetings in Atlantic City. Commencing on Sunday, June 18, the meetings ran through Thursday afternoon, June 22. Following the House session, various Reference Committee meetings to discuss the business matters before the House were held. All of those delegates and alternates present, as well as the Executive Secretary, attended assigned sessions and reported the general tenor of the discussions at these sessions.

It is important for all physicians to recognize, realize and take advantage of their opportunity to appear at Reference Committee meetings to speak on any subject in which they are interested.

The most important and widely attended sessions of the Reference Committees were those devoted to the action on Therapeutic Abortions as well as the AMA's Disability Insurance program.

Your delegates are pleased to report that in nearly all instances of items to come before the AMA House, that our own society already had taken action on the matters or had the question under discussion within various Faculty Committees. We are happy that the physicians of Maryland can consider themselves in the vanguard of the important decisions being made today that will affect the practice of medicine in future years.

A complete report of the House actions follows:

Actions of the House

Of the 10 reports from councils considered by the House, all were adopted in their presented form except two from the Council on Medical Service which were amended and adopted. Of the 18 Board of Trustees reports, 13 were adopted as presented; two were amended and adopted; two were accepted for information; and one was referred back to the Board along with state resolutions on the same subject.

Therapeutic Abortion

One subject that has generated interest not only in the profession but among legislatures and the public is therapeutic abortion.

The House updated the Association's 1871 policy on the subject which, according to the Reference Committee report which was adopted, was not only antiquated but lacked even the rudiments of adequate safeguards to prevent abuse. The updated policy, the House agreed, is in keeping with modern scientific knowledge, contains necessary safeguards and permits the physician to exercise his personal conscience and medical judgment in the best interest of his patient, over-riding objectives in any medical decision.

The following was established as policy of the American Medical Association:

". . . Recognizing that there are many physicians who, on moral or religious grounds, oppose therapeutic abortion under any circumstances, the American Medical Association is opposed to induced abortion except when:

(1) There is documented medical evidence that continuance of the pregnancy may threaten the health or life of the mother, or

(2) There is documented medical evidence that the infant may be born with incapacitating physical deformity or mental deficiency, or

(3) There is documented medical evidence that continuance of a pregnancy, resulting from legally established statutory or forcible rape or incest may constitute a threat to the mental or physical health of the patient;

(4) Two other physicians chosen because of their recognized professional competence have examined the patient and have concurred in writing; and

(5) The procedure is performed in a hospital acredited by the Joint Commission on Accreditation of Hospitals.

"It is to be considered consistent with the principles of ethics of the American Medical Association for physicians to provide medical information to State Legislatures in their consideration of revision and/or the development of new legislation regarding therapeutic abortion."

Health Care Cost

"Today . . . the ability of the physician to serve his patient is being handicapped by the rapidly rising prices of the various components of health care." That is a statement from the Board of Trustees report adopted by the House with the provision that it be widely disseminated for study and evaluation as to its applicability in local areas.

"Indeed," the report continued, "if the price of health care continues to outrun slower increases in consumers' income, the problem of medical indigency will assume alarming proportions."

Basic problems in the over-all design of the nation's health care system, as shown in the adopted report, include inadequate numbers of new physicians and shortages of other individuals trained to function as part of the health care team; the present organization and management of the nation's hospitals, with respect to their "privilege of automatically translating all higher costs into higher prices" which "must now be questioned;" diagnostic and therapeutic care outside of a hospital; and legislation in the health field.

A number of actions were taken to outline possible solutions to the problems of higher health care costs. One important one was the adoption of a progress report on strengthening and improving voluntary health insurance programs, submitted by the Council on Medical Service. The House accepted the Council's statements that it would "continue to study the scope and patterns of benefits, public demands for coverage, the performance of health insurance and prepayment programs and accumulation of data for future use;" and that the Council would "proceed to develop guiding principles for health insurance and prepayment programs."

As further efforts in this direction, the House referred to the Board and to the Council on Medical Service a resolution that the AMA "consult with insurers in an effort to change their policy of insurance coverage so that payment can be made for diagnostic procedures and minor surgery performed in the physicians' office and/or in the hospital out-patient department;" adopted a resolution that the Association petition congress to remove the restriction on first-dollar deduction from income tax laws for health care expenditures; and adopted the over-all policy that "physicians . . . continue to do everything possible to help the public conserve its health care dollars."

Government Health Programs

As might be expected, a great many reports and resolutions dealt directly or indirectly with the Association's relationships with government and with the multitude of government programs existing or proposed in the health field.

The House re-affirmed Association policy that "The medical profession has long and consistently held to two basic positions concerning personal health care and its financing: that no one should go without needed care because of inability to pay, and that responsibility for payment rests first on the individual himself and then, to the extent that he is unable to pay, on his family, the community, the county, the state, and, to the extent that lesser levels of government are unable to finance the care, the federal government."

Regarding the Title XIX program, the House made it policy that "the medical profession should now take a firm stand in support of the Title XIX approach in improving the health and the delivery of health care services to the needy of the nation."

Recommendations adopted by the House are that the medical profession take a strong stand in support of implementation of Title XIX "while still seeking such changes in the federal legislation and/or regulations as will improve this program; that it urge organized medicine to take a leading role in formulating and directing Title XIX programs at the state and local level . . . and that it incorporate in such planning the use of existing voluntary mechanisms and private insurance carriers, wherever feasible, utilizing the usual and customary fee principle, thus bringing within the mainstream of present medical care systems the provision of quality health care for all Americans."

Appalachian regional health programs were the subject of a number of resolutions and the House adopted the following guidelines for setting up any such programs: (1) demonstrated need for the proposed project; (2) local control; (3) participation of a significant proportion of local physicians in planning and development of the project; (4) the operation of any regional, area or county health service facility shall not infringe upon the private practice of medicine; (5) all health services, whether preventive, prophylactic or therapeutic, shall be rendered at a cost to the patient commensurate with the social and economic status of the patient; (6) there shall be adequate medical representation on all national, state and local bodies having supervision or jurisdiction in the development and/or operation of such health service facilities; (7) these health service projects shall in no way be developed, operated or influenced in any manner which could lead to a government-controlled system of medical practice.

More generally, in connection with any and all government medical care programs, guidelines were adopted by the House:

"The medical profession in any community is best represented by the local medical society and its officers. They should be consulted initially, and during the process of planning of any and all projects for the care of the sick and the preservation of health."

In proposing any new facility, "It shall be first determined that existing facilities are so inadequate that only a completely new facility will provide a solution.

"The responsibility for the health needs of a community basically resides at the community level, and all the local resources . . . shall be examined before the community accepts government monies.

"If it is deemed advisable to operate a government-financed facility in a community, it shall in no way be binding upon a physician to refer his patients there; to coerce a physician to service the facility; and this facility must in no way infringe upon the private practice of medicine.

"These projects should not be developed or operated in such a manner as to establish a precedent that could lead to a governmental controlled medical care system in this country."

Physician Control Over Collection and Disbursement of Professional Fees

In adopting a report of the Council on Medical Service regarding collection and disbursement of professional fees, the House reaffirmed past action and provided clear, consistent policy statements reflected in these thoughts which are elaborated in the full report:

1. It is proper for the physician to establish the fee he charges to any patient for professional service rendered, with the recognition that a duly constituted committee of his peers may appropriately review and pass upon the equity and justice of his charge.
2. It is proper for third party agencies to make payment of professional medical fees for patients.
3. It is proper for a physician to work with other physicians in a team approach to the provision of medical service, recognizing that each is entitled to compensation according to the value of his services and that charges attributable to each physician's service shall be made clear to the patient.
4. It is proper for a physician who provides personal supervision and direction for a physician-in-training to charge for the professional medical service rendered.
5. A physician should not enter into a contract or agreement with a hospital whereby the hospital acts as the agent for him unless it is with the consent of the physician and of the medical staff.
6. Physicians, collectively in hospitals, may properly establish special medical staff funds, wholly under their own control, which they may support as they see fit, disburse as they may agree.
7. Fees for professional medical services are properly paid only to the responsible physicians and may not be appropriated by any other person or agency.
8. The physician is the sole arbiter as to the ways he may dispose of his professional income, without duress, consistent with the laws of the land and the Principles of Medical Ethics of this Association.

Millis Commission and Commission on Research

Because the contents of the Millis Commission report (Citizens Commission on Graduate Medical Education) relate so specifically to the roles of the Councils on Medical Education and Medical Service, the two councils have assumed responsibility for assembling critiques and information. At a later date, they will bring to the Board, and subsequently to the House, recommendations for implementation of parts or the whole of the report. The House urged all interested members of the Associa-

tion or groups to submit comments, suggestions or recommendations for consideration by the two councils.

With respect to the Commission on Research, the Board has established a Committee on Research to review reports on the subject from the Councils on Medical Education and Medical Service; refer portions of the report to other councils and committees; and confer with those groups in addition to receiving their reports.

Again, the House urged any interested individuals and groups to forward comments and suggestions to the Executive Vice President for transmittal to the committee.

Medicine and Osteopathy

The House adopted the following recommendations of the Board regarding the medical profession's relationships with osteopathy:

1. Authorize the Board of Trustees to begin promptly negotiations directed toward beginning official change of schools of osteopathy to schools of medicine. (It is understood that from the American Medical Association funds will be required to conduct these negotiations, and assistance in identifying and securing additional funds from other sources to support efforts toward changing the schools.)

2. Authorize the Council on Medical Education to undertake negotiations to establish means by which selected students with proven satisfactory scholastic ability in schools of osteopathy may be considered by schools of medicine for transfer into medical school classes.

The primary issue in the relationship of medicine and osteopathy, as recognized by the House, seems to be not that of cultism as opposed to science. Rather the issue appears to be one level of medical education and practice as opposed to another and lower level of education and practice. The extensive and growing licensure of osteopathic physicians for the unrestricted practice of medicine and the nature of osteopathic education strongly indicate that time alone will resolve shortly the problem of cultism in relation to osteopathy.

Medical Manpower

The House accepted for information a report from the Board which pointed out that "The production of well qualified physicians in adequate numbers is necessary to meet effectively both social and economic demands for health care." It reviewed some of the activities of the Committee on Health Manpower and concluded that "The AMA should continue to study the effect of new roles for health personnel and new interrelationships and interdependencies between health professionals, as well as the impact of innovative concepts on the organizational structure evolving in the general system of health care delivery. . . .

"In any event, our resolve should always be as it is now: to use the best tested and most forward looking measures to provide excellent health care for all of our citizens through an ample number of able, educated and highly skilled physicians."

The House also referred to the Board, for consideration by the committee, a resolution that "deliberations include strong emphasis on sound ways of accelerating medical education in all its phases, including post-MD and graduate education, and of increasing the supply of physicians in all categories."

In addition, the House adopted reports calling for revision of the Essentials of Approved Residencies in radiology, obstetrics and gynecology; adopted a resolution calling for the promotion of better practices in inhalation therapy; and adopted a resolution that the AMA reaffirm its support of all forms of nursing education: that hospitals which conduct diploma schools of nursing be commended; that such hospitals be urged to continue their schools and increase enrollment; and that the AMA take appropriate action in consultation with professional nurses' associations and the American Hospital Association to encourage increasing enrollment in diploma schools and at the same time improve educational standards.

Committee on Planning and Development

At the June, 1966, convention of the House, the Board announced the appointment of a committee to study planning and development techniques within the Association. The report of the committee was received and the Board submitted its final report to the House at this convention.

The Board voted to (1) establish a permanent Committee on Planning and Development and (2) select seven active members of the AMA as members. The following charges were established for the committee:

1. Study and make recommendations concerning the long-range objectives of the Association and the resources, programs and organizational structure by which the Association attempts to reach them.

2. Serve as a focal point for the planning activities of the Association and stimulate and coordinate planning activities throughout the organization.

3. Study, or cause to be studied, medicine and the environment in which the Association must function and transmit the conclusions of these studies to the Board.

In the report adopted by the House, the Board earnestly solicited nominations to the committee from delegates, constituents associations, component societies and other interested groups and individuals.

Two resolutions on the subject were referred to the Board.

It is noteworthy that in his report to the House, President Rouse stated that "We now have an established Committee on Planning and Development at the AMA level. I hope that every county and state association will likewise make use of a comparable committee, to plan wisely and develop properly the policies and programs needed in the decades ahead—far beyond just the next year."

Members' Disability Insurance Program

The House adopted the report of the Reference Committee on this subject, and referred to the Board a number of resolutions pertaining to it.

The committee's report, as adopted, recommended that the House authorize the Board to make every effort to continue the AMA Members Group Disability Insurance Program with the same premium-benefit structure. It also recommended the following guidelines to aid the Board in negotiating and executing the necessary contracts and in the future operation of the program:

1. The contract should provide ample assurance that disability claimants will be treated equitably and justly.

2. The carrier should guarantee benefits and premiums for a period of at least five years in order to assure the stability of the program.

3. Promotional literature should be approved in advance by the Board or its designee. All measures within the bounds of dignity and ethics should be utilized to promote the program.

4. A continuous ongoing review of the entire program should be maintained. The insured and other members should be made

aware that such a review may reveal in the future the necessity for a revision of the program at the end of the five-year period.

5. Information regarding the operation of the program, its financial aspects and the processing of claims should be available to the Board for review at any time.

6. An AMA Disability Insurance Review Committee should be continued and should provide a mechanism for claims review.

Political Action

Several resolutions were offered to the House questioning whether the administration of government programs is truly carrying out the intent of Congress in its passage of laws. They were combined by the House into one resolution stating "That if legislation is introduced to investigate the activities of the Department of HEW and its executive personnel who are concerned with health matters to determine if the intent of Congress is being carried out, the American Medical Association will provide to such an investigation any information that its Board and councils may secure in these matters."

The resolution also pointed out that since the most effective method to preserve the private practice of medicine is to elect proper officials at all levels of government, "the American Medical Association urges that physicians, as individuals, redouble their efforts in political activities."

It was also resolved that the Association "continue and expand its efforts to inform our membership of its activities to represent them, particularly before the Congress and the federal agencies."

The House also adopted a resolution "That medical societies be urged to investigate, document and report to the Law Division . . . all violations of Public Law 89-97 by officers or employees of the federal government" and that "a status report be provided to this House at the 1967 Clinical Convention."

The House also reaffirmed the Association's opposition to S. 260 (the Hart Bill) and its support of direct billing under Part B of medicare on the basis of a physician's itemized statement of charges.

The House supported AMPAC and the state PAC orgainzations by adopting a resolution recognizing "that leadership at all levels of medicine should make individual commitment to state PAC-AMPAC membership and local PAC programs, wherever this is legally possible."

Generic Prescribing

A resolution combining several state resolutions was adopted by the House, asserting "that the AMA again reaffirm its policy that physicians should be free to use either the generic or the brand names in prescribing drugs for their patients; and encourage physicians to supplement medical judgments with cost considerations in making this choice."

Other Actions

During the convention, the House welcomed 15 physicians who have served in the Volunteer Physicians for Vietnam program; conducted a memorial service for 27 members of the House and/or officers of the Association who had died since the 1965 Annual Convention; heard a report on AMPAC from Blair J. Henningsgaard, MD, chairman of the AMPAC Board; heard a report on AMA-ERF from Immediate Past President James Z. Appel, MD, President of AMA-ERF; permitted a representative from the Oregon Woman's Auxiliary to introduce to the House the "Doctor's Wife," a new rose developed by the Oregon auxiliary; and heard a talk by David Kindig, president of the Student American Medical Association.

Adopted many other resolutions, including these:

Amending the bylaws so that recipients of the Distinguished Service Award and the Citation of a Layman for Distinguished Service will be nominated at the Clinical Convention and the presentations will be made at the next Annual Convention.

Confirming that there is nothing in the military officers' oath that conflicts in any way wiith the ethics of the medical profession.

Noting that a double standard of policy often exists between so-called "hospital-based specialists" and other types of practitioners with respect to hospital staff appointments and endorsing "the principle of a single standard with respect to staff appointments among all physicians having equivalent credentials in all hospital departments and services as a means of assuring maximum freedom of choice of physicians by patients, and of consultants by staff members."

Requesting the JCAH to "encourage . . . the acceptance, wherever possible, of physicians elected or appointed by the medical staff to the Board of Trustees with full voting rights as the most effective form of liaison between the medical staff and hospital governing authorities."

Opposing the establishiment of a racial quota system for hospitals.

Encouraging farm equipment manufacturers to establish standards for basic overturn protective frames and crush-resistant cabs.

Reaffirming the Association's policy regarding tobacco and health and promising vigorous continuation of its measures for corrective action.

Urging that disposable hypodermic syringes be thrown away in such a way as to prevent their possible re-use.

Encouraging state associations to inform state legislators of the need to re-examine existing "battered child" laws so child abuse is to be reported by physicians as well as medically oriented social services.

Supporting continued research and control measures for venereal disease.

Reaffirming the Association's opposition to requirements for certification and re-certification.

Stating the Association's continuing concern for the prevention of death and injury from burns by "stepping up its education campaign to make the public more aware of the dangers inherent in flammable fabrics and other related flammable materials" and resolving that "the AMA cooperate with other voluntary associations in the furtherance of this program."

Finally, the House welcomed as its guests at the opening session the winners of the AMA's top awards at the 18th International Science Fair, held in San Francisco. They were Susan T. Bertrand, New Albany, Ind., whose exhibit was "Electrophoretic Analysis of Blood Serum;" and Stephen R. Igo, Winterset, Iowa, with an exhibit showing the design, construction and operation of a small, synchronous intrathoracic auxiliary ventricle. Both winning exhibits were on display during the convention.

Respectively submitted,
Robert vanL. Campbell
J. Sheldon Eastland
Russell S. Fisher
William B. Hagan

BYLAWS COMMITTEE

Mr. President and Members of the House of Delegates:

The Bylaws Committee recommends the following changes in the Bylaws:

Explanation: In order that the Bylaws accurately reflect the procedures followed wherein the Faculty collects most of the Component Society dues, the following amendment is submitted.

Amend Article III, Section 1, by adding: "if they are not being collected through the facilities of the Faculty by agreement between the Faculty and the Component Society:"

OLD

Section 1. On or before January 31 each year, the Secretary of each component society shall forward to the Secretary of the Faculty (1) a complete roster of members during the preceding year with their addresses, noting any change in membership by death, removal or otherwise, and listed according to the type of membership held, (2) a list of the component societies' officers and (3) a list of the delegates and alternates to the House of Delegates. The Secretary shall also forward the following per capita annual dues:

(a) *FOR ACTIVE MEMBERS:* $25.00 for the first year in private practice; $35. for the second year in private practice; $75. annually thereafter.

(b) *FOR ASSOCIATE MEMBERS:* $25.00 for those described in Article II, Section 2 (1) (2) and (5); $10.00 for those described in Article II, Section 2 (3) and (4); and $5.00 for those described in Article II, Section 2 (6) and (7).

(c) *FOR AFFILIATE MEMBERS:* $15.00 for those described in Article II, Sections 2 (1) and (2).

(d) All other classes of membership shall not be required to pay dues.

NEW

(CAPS portion to be added)

Section 1. On or before January 31 each year, the Secretary of each component society shall forward to the Secretary of the Faculty (1) a complete roster of members during the preceding year with their addresses, noting any change in membership by death, removal or otherwise, and listed according to the type of membership held, (2) a list of the component societies' officers and (3) a list of the delegates and alternates to the House of Delegates. The Secretary shall also forward the following per capita annual dues IF THEY ARE NOT BEING COLLECTED THROUGH THE FACILITIES OF THE FACULTY BY AGREEMENT BETWEEN THE FACULTY AND THE COMPONENT SOCIETY:

(a) *FOR ACTIVE MEMBERS:* $25.00 for the first year in private practice; $35. for the second year in private practice; $75. annually thereafter.

(b) *FOR ASSOCIATE MEMBERS:* $25.00 for those described in Article II, Section 2 (1) (2) and (5); $10.00 for those described in Article II, Section 2 (3) and (4); and $5.00 for those described in Article II, Section 2 (6) and (7).

(c) *FOR AFFILIATE MEMBERS:* $15.00 for those described in Article II, Sections 2 (1) and (2).

(d) All other classes of membership shall not be required to pay dues.

Explanation: Resolutions dealing with insignificant matters have been submitted quite frequently in the past. In order to ensure that the House of Delegates time is used to the best advantage, the following Bylaw amendment is proposed.

Amend Article VI, Section 4, by adding, "provided, however, that a resolution introduced by an individual member must have the endorsement of his Component Society."

OLD

Section 4. All resolutions involving questions of Faculty policy which will be presented to the House of Delegates for action shall be filed with the Executive Secretary and sent to all delegates with the call for the session, provided that by a two-thirds vote the House of Delegates may agree to consider any policy resolution without prior notice. No such resolution shall be accepted by the Executive Secretary which is not sponsored by a member or component society of the Faculty, the Council or committees of the Faculty.

NEW

(CAPS portion to be added)

Section 4. All resolutions involving questions of Faculty policy which will be presented to the House of Delegates for action shall be filed with the Executive Secretary and sent to all delegates with the call for the session, provided that by a two-thirds vote the House of Delegates may agree to consider any policy resolution without prior notice. No such resolution shall be accepted by the Executive Secretary which is not sponsored by a member or component society of the Faculty, the Council or Committee of the Faculty, PROVIDED, HOWEVER, THAT A RESOLUTION INTRODUCED BY AN INDIVIDUAL MEMBER MUST HAVE THE ENDORSEMENT OF HIS COMPONENT SOCIETY.

Explanation: Over the years, Committee functions have been changed as programs become obsolete and new ones come into existence. All of the following amendments are offered as housekeeping provisions to the Bylaws. All of the Committees have been consulted and are in basic agreement with these amendments.

Amend Article XI, Section 1. by striking out the entire section.

OLD

Section 1. AN AMERICAN MEDICAL EDUCATION AND RESEARCH FOUNDATION COMMITTEE of at least five members shall cooperate with the American Medical Education and Research Foundation. Its chairman shall be appointed by the President and said chairman shall appoint the other members of the Committee with the approval of the President.

Amend Article XI, Section 4, by striking out the entire section and substituting the following new section:

Section 4. A Medical Economics Committee of at least five members shall serve as a *Review Committee* for health insurance and other third party payors to determine equitable and just fees for procedures performed and for which such carriers are responsible. It may only act on the request of the carrier or patient involved, and after the medical service has been rendered. It shall not determine the legal rights or benefits under such policies. It shall also be empowered to investigate, within the responsibilities and charges designated in these bylaws, areas of economic benefits for members of the Faculty. It shall receive the report of the Faculty's officially approved Professional Liability Program and shall prepare and present an educational program to physicians in this regard. Its chairman shall be appointed by the President and said chairman shall appoint the other members of the Committee with the approval of the president. The Baltimore City Dental Society shall have the right to elect one associate member of the committee with voice but no vote.

OLD

(Italicized portions to be deleted)

Section 4. AN ECONOMICS COMMITTEE of at least five members shall serve in an advisory capacity for the Medicare Program; conduct a continuing investigaion regarding group insurance on a State-wide basis and confer with insurance carriers concerning insurance problems relating to specialties such as radiology, pathology and anesthesiology. Its chairman shall be appointed by the President and said chairman shall appoint the other members of the committee with the approval of the President. The Baltimore City Dental Society shall have the right to elect one associate member of the committee with voice but without vote.

NEW

(CAPS portion to be added)

Section 4. A MEDICAL ECONOMICS COMMITTEE OF AT LEAST FIVE MEMBERS SHALL SERVE AS A *REVIEW COMMITTEE* FOR HEALTH INSURANCE AND OTHER THIRD PARTY PAYORS TO DETERMINE EQUITABLE AND JUST FEES FOR PROCEDURES PERFORMED AND FOR WHICH SUCH CARRIERS ARE RESPONSIBLE. IT MAY ONLY ACT ON THE REQUEST OF THE CARRIER OR PATIENT INVOLVED, AND AFTER THE MEDICAL SERVICE HAS BEEN RENDERED. IT SHALL NOT DETERMINE THE LEGAL RIGHTS OR BENEFITS UNDER SUCH POLICIES. IT SHALL ALSO BE EMPOWERED TO INVESTIGATE, WITHIN THE RESPONSIBILITIES AND CHARGES DESIGNATED IN THESE BYLAWS, AREAS OF ECONOMIC BENEFITS FOR MEMBERS OF THE FACULTY. IT SHALL RECEIVE THE REPORT OF THE FACULTY'S OFFICIALLY APPROVED PROFESSIONAL LIABILITY PROGRAM AND SHALL PREPARE AND PRESENT AN EDUCATIONAL PROGRAM TO PHYSICIANS IN THIS REGARD. ITS CHAIRMAN SHALL BE APPOINTED BY THE PRESIDENT AND SAID CHAIRMAN SHALL APPOINT THE OTHER MEMBERS OF THE COMMITTEE

WITH THE APPROVAL OF THE PRESIDENT. THE BALTIMORE CITY DENTAL SOCIETY SHALL HAVE THE RIGHT TO ELECT ONE ASSOCIATE MEMBER OF THE COMMITTEE WITH VOICE BUT NO VOTE.

Amend Article XI, Section 5, by striking out the words, "and Business Manager."

OLD

(Italicized portions to be deleted)

Section 5. There shall be an *EDITORIAL BOARD* composed of the Editor *and Business Manager of the Maryland State Medical Journal* and six members, two of whom shall be appointed by the President each year for a three-year term.

NEW

(CAPS portion to be added)

Section 5. There shall be an *EDITORIAL BOARD* composed of the Editor of the *Maryland State Medical Journal* and six members, two of whom shall be appointed by the President each year for a three-year term.

Amend Article XI, Section 7, by striking out,
"A Fee Schedule Committee to consider and advise the Faculty on all questions relating to Fee Schedules shall be composed of" and substituting:

Section 7. "A Professional Medical Services Committee shall consider and advise the Faculty on all matters relating to the professional services provided to the public by members of the Faculty. It shall not conflict in any way with charges made in these bylaws to other committees of the Faculty. It shall make available facts, data and opinions with respect to timely and adequate rendition of medical care to the public; to investigate matters pertaining to the economics of medical practice and where related, social aspects of medical care; it shall study means for the distribution of medical service to the public consistent with the principles adopted by the Faculty's House of Delegates and the AMA's House of Delegates. It shall be composed of. . . ."

OLD

(Italicized portions to be deleted)

Section 7. *A FEE SCHEDULE COMMITTEE to consider and advise the Faculty on all questions relating to fee schedules shall be composed of* (1) a chairman appointed by the President, (2) five members of the Faculty selected by the President, (3) one general practitioner from each councilor district selected by the President from among a group composed of one nominee elected by each component society and (4) one representative selected by each state-wide specialty group which desires

NEW

(CAPS portion to be added)

Section 7. A PROFESSIONAL MEDICAL SERVICES COMMITTEE SHALL CONSIDER AND ADVISE THE FACULTY ON ALL MATTERS RELATING TO THE PROFESSIONAL SERVICES PROVIDED TO THE PUBLIC BY MEMBERS OF THE FACULTY. IT SHALL NOT CONFLICT IN ANY WAY WITH CHARGES MADE IN THESE BYLAWS TO OTHER COMMITTEES OF THE FACULTY. IT SHALL MAKE AVAILABLE FACTS, DATA AND OPINIONS WITH representation. The Baltimore City Dental Society shall have the right to elect one associate member of the committee with voice but without vote.

RESPECT TO TIMELY AND ADEQUATE RENDITION OF MEDICAL CARE TO THE PUBLIC; TO INVESTIGATE MATTERS PERTAINING TO THE ECONOMICS OF MEDICAL PRACTICE AND WHERE RELATED, SOCIAL ASPECTS OF MEDICAL CARE; IT SHALL STUDY MEANS FOR THE DISTRIBUTION OF MEDICAL SERVICE TO THE PUBLIC CONSISTENT WITH THE PRINCIPLES ADOPTED BY THE FACULTY'S HOUSE OF DELEGATES AND THE AMA'S HOUSE OF DELEGATES. IT SHALL BE COMPOSED OF (1) a chairman appointed by the President, (2) five members of the Faculty selected by the President, (3) one general practitioner from each councilor district selected by the President from among a group composed of one nominee elected by each component society and (4) one representative selected by each state-wide specialty group which desires representation. The Baltimore City Dental Society shall have the right to elect one associate member of the committee with voice but without vote.

Amend Article XI, Section 11, by striking out the following:

Section 11. "A Liaison Committee of at least ten members shall provide from among its membership such liaison as is required on the following subjects: Veterans medical care, accreditation of hospitals, adoption and vocational rehabilitation, and to the follwing organizations: Bureau of Old Age and Survivor's Insurance, State Department of Health and Maryland Pharmaceutical Association."

and substituting the following:

Section 11. "A Liaison Committee of at least ten members shall provide from among its membership such liaison as is required with other professional organizations, such as but not limited to: Maryland Nurses Association, Maryland Pharmaceutical Association, State Department of Health, all specialty medical organizations in the state. It shall not conflict in any way with charges made in these bylaws to other committees of the Faculty."

OLD

(Italicized portions to be deleted)

Section 11. *A LIAISON COMMITTEE of at least ten members shall provide from among its membership such liaison as is required on the following subjects: Veterans medical care, accreditation of hospitals, adoption and vocational rehabilitation; and to the following organizations: Bureau of Old Age and Survivors Insurance, State Department of Health and Maryland Pharmaceutical Association.* Its chairman shall be appointed by the President and said chairman shall appoint the other members of the committee with the approval of the President. The Baltimore City Dental Society shall have the right to elect one associate member of the committee with voice but without vote.

NEW

(CAPS portion to be added)

Section 11. A LIAISON COMMITTEE OF AT LEAST TEN MEMBERS SHALL PROVIDE FROM AMONG ITS MEMBERSHIP SUCH LIAISON AS IS REQUIRED WITH OTHER PROFESSIONAL ORGANIZATIONS, SUCH AS BUT NOT LIMITED TO: MARYLAND NURSES ASSOCIATION, MARYLAND PHARMACEUTICAL ASSOCIATION, STATE DEPARTMENT OF HEALTH, ALL SPECIALTY MEDICAL ORGANIZATIONS IN THE STATE. IT SHALL NOT CONFLICT IN ANY WAY WITH CHARGES MADE IN THESE BYLAWS TO OTHER COMMITTEES OF THE FACULTY. Its chairman shall be appointed by the President and said chairman shall appoint the other members of the committee with the approval of the President. The Baltimore City Dental Society shall have the right to elect one associate member of the committee with voice but without vote.

Amend Article XI, Section 13, by striking out the second sentence as follows:

"This Committee shall meet with labor unions, professional organizations and others interested in improving the quality of medical care, for discussion and consideration of questions of mutual interest in this area."

OLD

(Italicized portions to be deleted)

Section 13. *A MEDIATION COMMITTEE* composed of the five most recent living Immediate Past Presidents, the Chairman of the Council, and not more than five additional members appointed by the President shall hear and determine all grievances or complaints involving or growing out of the practice of medicine as provided by these bylaws and mediate all problems involving or growing out of the practice of medicine. *This committee shall meet with labor unions, professional organizations and others interested in improving the quality of medical care, for discussion and consideration of questions of mutual interest in this area.* The chairman shall be appointed by the President. The Baltimore City Dental Society shall have the right to elect one associate member of the committee with voice but without vote in all committee deliberations except those relating to grievances or complaints.

NEW

(CAPS portion to be added)

Section 13. *A MEDIATION COMMITTEE* composed of the five most recent living Immediate Past Presidents, the Chairman of the Council, and not more than five additional members appointed by the President shall hear and determine all grievances or complaints involving or growing out of the practice of medicine as provided by these bylaws and mediate all problems involving or growing out of the practice of medicine. The chairman shall be appointed by the President. The Baltimore City Dental Society shall have the right to elect one associate member of the committee with voice but without vote in all com-

mittee deliberations except those relating to grievances or complaints.

Amend Article XI, Section 18, by striking out the second sentence which reads: "It shall serve in an advisory capacity to the State Accident Fund."

OLD

(Italicized portions to be deleted)

Section 18. *AN OCCUPATIONAL HEALTH COMMITTEE* of at least five members shall study and report as it deems advisable upon occupational disease programs and health programs in industry. *It shall serve in an advisory capacity to the State Accident Fund.* Its chairman shall be appointed by the President and said chairman shall appoint the other members of the committee with the approval of the President.

NEW

(CAPS portion to be added)

Section 18. *AN OCCUPATIONAL HEALTH COMMITTEE* of at least five members shall study and report as it deems advisable upon occupational disease programs and health programs in industry. Its chairman shall be appointed by the President and said chairman shall appoint the other members of the committee with the approval of the President.

Amend Article XI, Section 20, by striking out the following:

". . . subjects, among others: diabetes, geriatrics, maternal and child welfare, pelvic cancer, rural health, tuberculosis, prevention of automotive highway disasters, regulations relating to hospital licensing, immunizations and alcoholism."

and insert the following:

". . . postgraduate educational programs, any health topic or subject that is of general interest to Faculty members, all phases of medical education, public health matters and all aspects of preventive medicine and health maintenance. It shall not conflict in any way with charges made in these bylaws to other committees of the Faculty."

OLD

(Italicized portions to be deleted)

Section 20. *A COMMITTEE ON POSTGRADUATE EDUCATION, PREVENTIVE MEDICINE AND PUBLIC HEALTH* of at least eight members shall consider and advise upon the following *subjects, among others: Diabetes, geriatrics, maternal and child welfare, pelvic cancer, rural health, tuberculosis, prevention of automotive highway disasters, regulations relating to hospital licensing, immunizations and alcoholism.* Its chairman shall be appointed by the President and said chairman shall appoint the other members of the committee with the approval of the President.

NEW

(CAPS portion to be added)

Section 20. *A COMMITTEE ON POSTGRADUATE EDUCATION, PREVENTIVE MEDICINE AND PUBLIC HEALTH* of at least eight members shall consider and advise upon the following POSTGRADUATE EDUCATIONAL PROGRAMS, ANY HEALTH TOPIC OR SUBJECT THAT IS OF GENERAL INTEREST TO FACULTY MEMBERS, ALL PHASES OF MEDICAL EDUCATION, PUBLIC HEALTH MATTERS AND ALL ASPECTS OF PREVENTIVE MEDICINE AND HEALTH MAINTENANCE. IT SHALL NOT CONFLICT IN ANY WAY WITH CHARGES MADE IN THESE BYLAWS TO OTHER COMMITTEES OF THE FACULTY."

These changes in the Bylaws, insofar as the committee name and charges shall take effect on the date of the adoption. It is understood that the committee composition will not necessarily change until the date of the Annual Meeting when such committee appointments normally expire.

The following amendment is offered because of incorrect wording that has been in the Bylaws since 1962. This will correct this long-standing error.

Amend Article XIII, Section 3, in the second section by striking out the word "Council" where it first appears in that sentence and inserting the word "Committee."

OLD

(Italicized portions to be deleted)

Section 3. The Committee's findings and recommendations in the form of resolutions shall be filed with the Council for consideration and action, provided that the Committee may, of its own motion, refer the matter to the Board of Medical Examiners. Any party aggrieved by the action of the *Council* may, within 30 days of such action, file an appeal in writing with the Council which shall hear the appeal on the record allowing only such additional evidence as is newly discovered.

NEW

(CAPS portion to be added)

Section 3. The Committee's findings and recommendations in the form of resolutions shall be filed with the Council for consideration and action, provided that the Committee may, of its own motion, refer the matter to the Board of Medical Examiners. Any party aggrieved by the action of the COMMITTEE may, within 30 days of such action, file an appeal in writing with the Council which shall hear the appeal on the record allowing only such additional evidence as is newly discovered.

Respectively submitted,
CHARLES F. O'DONNELL, MD, *Chairman*
ROBERT VANL. CAMPBELL, MD
ARTHUR T. KEEFE, JR., MD
EDMOND J. MCDONNELL, MD

LIAISON COMMITTEE PROPOSED PHYSICIAN/PHARMACIST CODE OF COOPERATION

Mr. President and Members of the House of Delegates:

Preamble

Acknowledging that the practice of medicine and pharmacy needs the combined services of both groups, this Code of Cooperation is hereby adopted as a declaration of principles of conduct for the two professions to follow. It is clearly understood that local laws, regulations and Codes of Ethics of both professions clearly take precedence over these principles of conduct.

It is the hope of the two professions that the adoption of this Code of Cooperation will result in an improved understanding and closer relationship between the professions of medicine and pharmacy in the interest of better health care.

Physician

The American Medical Association's Code of Ethics states, in part:

"It is not unethical for a physician to prescribe or supply drugs, remedies or appliances as long as there is no exploitation of the patient."

Notwithstanding this statement, the Medical and Chirurgical Faculty of the State of Maryland believes that drug dispensing by physicians should be discouraged if adequate pharmaceutical service is available. A physician's professional source of income should be from the services he renders to his patients, and only from this source.

Physicians collectively, through the Medical and Chirurgical Faculty, recognize the following:

1. A patient should be permitted the free choice of his pharmacy, just as he should be permitted free choice of physician.
2. Physicians should not advise a patient as to the charge for professional pharmaceutical service.
3. The physician should cooperate with a pharmacist by specifying the number of times a prescription is to be refilled, and by making himself available to the pharmacist to determine whether or not his original orders should be altered after the original number of refills has been obtained. A prescription should never be marked for a refill contrary to current laws or regulations.
4. Physicians may, at their own discretion, indicate on the prescription order they write, that the prescription label include the name of the drug ingredients, as well as any other information deemed necessary. This is an individual decision and one that will depend upon the expert judgment of the physician based on the patient as an individual. (House of Delegates 5/64).
5. Physicians should not dispose of drug samples to pharmacists for any consideration, either direct or indirect. The use of drug samples in a physician's practice should be done in a manner that recognizes the position of the pharmacist in his role as a provider of drugs to the public. It is the responsibility of the physician to dispose of any undesired drug samples only through destruction, disposition to charitable organizations or through the approved program of the Woman's Auxiliary of the local medical societies. In no event should such drug samples be disposed of in a manner that would permit their falling into the hands of unauthorized persons.
6. Physicians should not enter into any rental, ownership or financial agreements or any other activity with pharmacists that would directly or indirectly affect the prescribing of medication by a physician in favor of a particular pharmacy or pharmacies.
7. The patient is always entitled to a written prescription It is recognized, however, that it is permissible for a phsician to prescribe by telephone to pharmacists of the patient's choice rather than writing prescriptions out individually.
8. Sale of drug samples either to patients or others, which have been given free to physicians is to be condemned. In general, complimentary drugs should be used only as starter doses. (Council, 11/21/61)
9. Mail order prescriptions are condemned, as this method of handling vital prescription matters would seem sharply at variance with the detailed, personal, professional care so essential to the safe distribution of prescription drugs. (House of Delegates, 9/14/62)
10. The use of prescription blanks imprinted with the name of a pharmacist, pharmacists or pharmacy is specifically prohibited by law.
11. Physicians are free to use either the generic or brand name in prescribing drugs for their patients. However, physicians should consult with the pharmacist as a member of the medical team in order to assure that the patient is properly served by being provided with medication of the highest quality.
12. Physicians should not write prescription orders in "code."
13. Physicians' bills should include only those charges for professional services rendered by him or under his supervision.
14. When prescription blanks are not imprinted with a physician's name, his name and degree should be printed or typed legibly below his signature.

Pharmacists

Recognizing that pharmacists and physicians must work as a team, the pharmacists, through the Maryland Pharmaceutical Association—the state professional pharmaceutical society—hereby adopt the following principles: It is understood that the foregoing principles for physicians, insofar as they affect the profession of pharmacy are also subscribed to by the profession of pharmacy. It is also understood that some of these principles are present-

ly incorporated in Federal and State laws and regulations as standards and requirements for pharmacy practice.

Pharmacy recognizes the inestimable value of the professional pharmacist to the health team, encourages him to fulfill completely the professional requirements of his calling, and desires that he decrease his activities in commercial enterprises which presently may be associated with but are not and should not be related to the practice of pharmacy.

1. Pharmacists, as well as physicians, are obligated to serve the public whenever their services are needed. On nights, Sundays and Holidays prescription services should be readily available in cases of emergency.
2. The pharmacist should never diagnose or prescribe, even at the insistence of the patient but should refer those needing medical attention to a physician of the patient's choice.
3. The sale of proprietary products and home remedies that have been approved by the Federal Food and Drug Administration for over-the-counter sale for self-medication shall not be considered counter prescribing by the pharmacist.
4. In an emergency, or preceding arrival of the physician, the pharmacist will render such emergency treatment as is indicated by his training, experience, scientific knowledge and good judgment.
5. If there is any question in the pharmacist's mind regarding the ingredients or labelling instructions of a prescription order, possible error or safety of the drug, he should privately and tactfully consult the physician before making changes and never discuss it with, or in the presence of, the patient.
6. There should be no substitution of ingredients by the pharmacist, and he should follow the prescriber's directions in the refilling of prescription orders. If no refilling instructions are contained on the original prescription, the pharmacist should not, in accordance with law, refill such prescriptions without the authority of the prescriber.
7. The pharmacist should not discuss the composition of a prescription or its therapeutic effects with the patient except when in the best interest of the patient he finds it necessary to identify or differentiate medication. When such questions arise he should tactfully suggest that the prescriber is the proper person with whom such matters should be discussed.
8. The pharmacist shall be responsible for providing a comprehensive supply of drugs on which the physician may draw by prescription order for the treatment of his patient and serve as a source of information on new drugs and their combinations in order that the physician and his patient may have the advantage of the latest pharmaceutical developments.

General

Neither physicians nor pharmacists should approach each other with respect to the completion of illegal arrangements such as pharmacists working as an employee of a physician. Prarmacists shall not engage in, and physician's shall not accept, advertising of a pharmacy in a physician's office or wating room.

The physician has a responsibility to make clear to the patient that even though a specific drug may be expensive, it is the best therapeutic agent he feels can be administered in treating the condition of the patient. Pharmacists, in turn, should not comment on the efficacy of the drug prescribed or of a substitute drug.

Publicity in connection with professional activities of either pharmacists or physicians should be cleared through the appropriate professional group. In all cases, news or feature stories affecting both professions should be developed cooperatively by the two groups.

Respectively submitted,
WILLIAM L. STEWART, MD, *Chairman*
MELVIN N. BORDEN, MD
JOSEPH P. CAPPUCCIO, DDS
ROBERT E. FARBER, MD
PAUL F. GUERIN, MD
JOHN H. HIRSCHFELD, MD
JOHN KEHOE, MD
W. KENNETH MANSFIELD, MD
DONALD W. MINTZER, MD
WILLIAM J. PEEPLES, MD
JOHN F. SCHAEFER, MD
H. LEONARD WARRES, MD

PHARMACY LIAISON SUBCOMMITTEE: Melvin N. Borden, Chairman; Morris R. Yaffe, John F. Schaefer, MD, Edgar P. Williamson, III, MD, Nathan I. Gruz, Wilfred H. Gluckstern, Victor H. Morgenroth, Jr.

AD HOC COMMITTEE TO CONSIDER CHANGES IN THE MEDICAL PRACTICE ACT

(Accepted and Referred to House of Delegates for Adoption)

Mr. President and Members of the House of Delegates:

The Commission on Medical Discipline of Maryland, hereby established and hereafter referred to in this Chapter as the Commission, shall consist of the following persons:

Dean of the Johns Hopkins University School of Medicine
Dean of the University of Maryland School of Medicine
The President of the Medical and Chirurgical Faculty of the State of Maryland.
The Immediate Past-President of the Medical and Chirurgical Faculty of the State of Maryland
The President-elect of the Medical and Chirurgical Faculty of the State of Maryland
Two Practicing Physicians appointed by the Governor of the State of Maryland from a list submitted by the Medical and Chirurgical Faculty of the State of Maryland
The Chief Medical Examiner of the State of Maryland
The President of the Board of Medical Examiners of the State of Maryland

Seven of the nine members of the Commission shall constitute a quorum for the transaction of all business.

The Commission may establish and maintain an office within this State and shall make, adopt and promulgate rules and regulations for its own government and for the proper supervision and control of the professional conduct of all persons under its jurisdiction, not inconsistent with the laws of this State or of the United States.

There shall always be nine members and no person shall serve in a dual capacity. In the event of such occurrence, the Governor may designate a practicing physician from a list submitted by the Medical and Chirurgical Faculty.

Terms of Office: The terms of office for appointees shall be for three years or until his successor is duly elected, appointed or qualified. Terms of office shall be from the 1st of July each year, except when the initial appointments are made; such appointment will be for staggered terms so as to provide for continuity on the Commission.

Reports: The Commission shall make annual reports to the Governor and to the Medical and Chirurgical Faculty of the State of Maryland.

Removal of Members: Any member of the Commission may be removed by the Governor for neglect of duty, misconduct or malfeasance or misfeasance in office.

Compensation: Members of the Commission may be reimbursed for actual expenses incurred in connection with their official duties with the Commission.

Duties and Obligations: The Commission shall refer any cases coming to its attention to the appropriate Committee of the Medical and Chirurgical Faculty of the State of Maryland for investigation and report. The report shall contain such recommendations as the investigation reveals might be necessary for adequate disciplinary procedures. Such recommendations will then be considered by the Commission which will take whatever action it deems appropriate.

The Medical and Chirurgical Faculty of the State of Maryland may initiate action by virtue of information coming to its attention from its own members or through any other source, such cases being handled in the same manner as though they had been referred to it by the Commission.

Power and Duties: The Commission shall have the power to revoke or suspend the license of or place on probation any licensed physician in the State of Maryland, for any of the causes listed below as unprofessional conduct, but such action shall not be limited to these causes:

1. Failure or refusal of a physician, without adequate cause, to render, or to arrange to have another physician render, necessary medical attention to any patient under his immediate care.
2. Rendering professional services to a patient if the physician is intoxicated or under the influence of narcotic drugs.
3. Having been found by a court of competent jurisdiction (within or without the State) to have exercised in the Practice of Medicine undue influence on a patient for financial gain.
4. Promotion by a physician of the sale of drugs, devices, appliances or goods provided for a patient in such a manner as to exploit the patient for financial gain of the physician.
5. Immoral conduct of a physician in his practice as a physician.
6. Willfully making and filing false reports or records, in his practice as a physician.
7. Willful omission to file or record, or willfully impeding or obstructing a filing or recording, or inducing another person to omit to file or record medical reports required by law.
8. Failure to furnish details of a patient's medical record to succeeding physicians or hospital upon proper request.
9. Solicitation of professional patronage by agents or persons, or profiting from the acts of those representing themselves to be agents of the licensed physician.
10. Division of fees, or agreeing to split or divide the fees received for professional services with any person for bringing to or referring a patient.
11. Accepting rebates or kickbacks, in any form whatsoever, for referral of patients.
12. Advertising professional superiority or the performance of professional services in a superior manner.
13. Willful misrepresentation in treatments.
14. Practicing medicine with an unlicensed physician except in an accredited preceptorship or residency training program; or aiding, abetting such unlicensed person in the practice of medicine.
15. Gross and willful and continued overcharging for professional services; including filing of false statements for collection of fees for which services are not rendered.
16. Offering, undertaking or agreeing to cure or treat disease by a secret method, procedure, treatment or medicine.
17. Revocation of license by any other state or territory for any cause whatsoever.
18. Professional or Mental Incompetency.

Legal Advisor: The Commission shall have the authority to hire professional legal advice and shall not be restricted to the use of the Attorney-General's office for such legal advice.

Immunity from Suit: All persons acting as members of authorized committees of the Medical and Chirurgical Faculty of the State of Maryland or as the Commission shall be immune from suit in any action, at law or equity, based upon any disciplinary proceedings or other official acts in the furtherance hereof and performed in good faith.

Subpoena: The Commission shall have the power to issue subpoenas and administer oaths in connection with any investigation, hearing or proceeding.

Certificate of revocation or suspension—Reprimand. If a majority of the members of the Commission vote in favor of finding the accused guilty of unprofessional conduct as specified in the charges, the Commission shall prepare written findings of fact and may thereafter prepare and file in the office of the Board of Medical Examiners a certificate or order of revocation, suspension or reprimand in which case a copy therof shall be served upon the accused.

Dismissal of charges—Exoneration. If the license holder is found not guilty, or if less than a majority of the members vote for a finding of guilty, the Commission shall forthwith order a dismissal of the charges and the exoneration of the accused.

Revocation or suspension of license—Stay pending review. The filing by the Commission in the office of the Board of Medical Examiners of a certificate or order of revocation or suspension, after due notice, hearing and findings in accordance with the procedure specified in this chapter, certifying that any holder of a license has been found guilty of unprofessional conduct by the Commission shall constitute a revocation or suspension of the license to practice medicine and surgery in this state in accordance with the terms and conditions imposed by the Commission and embodied in the certificate or order of revocation or suspension. If the licensee seeks judicial review of the Commission's decision pursuant to the provisions of this chapter, such revocation or the period of such suspension shall be stayed and shall not be effective or commence to run until final judgment has been entered in any proceeding instituted under the provisions of this chapter and the licensee's judicial remedies exhausted hereunder.

Contents of certificate—Recording. The certificate or order of revocation or suspension shall contain a brief and concise statement of the ground or grounds upon which the certificate or order is based and the specific terms and conditions of such revocation or suspension, and shall be retained as a permanent record by the Board of Medical Examiners as well as by the Commission.

Issuance of license after revocation or suspension. The Board of Medical Examiners shall not issue any license or any renewal thereof to any person whose license has

been revoked or suspended by the Commission except in conformity with the terms and conditions of the certificate or the order of revocation or suspension, or in conformity with any order of reinstatement issued by the Commission or in accordance with the final judgment in any proceeding for review.

Appeal from decision of Commission. Any person whose license has been revoked or suspended by the Commission shall have the right to a judicial review of the Commission's decision. Such review shall be initiated by serving on the Commission a notice of appeal within thirty days after the filing of the certificate or order of revocation or suspension in the office of the Board of Medical Examiners.

Respectively submitted,
JOHN MURRAY DENNIS, MD, *Chairman*
LEWIS P. GUNDRY, MD
KARL F. MECH, MD
WILLIAM A. PILLSBURY, MD

MEDICOLEGAL COMMITTEE

Mr. President and Members of the House of Delegates:

The Medicolegal Committee presents the following amendment to the Medicolegal Code of Cooperation:

AMEND THE FIRST SENTENCE OF PARAGRAPH TWO OF THE MEDICOLEGAL CODE OF COOPERATION TO READ:

The patient, or his attorney, upon written request, when accompanied by a signed authorization from the patient shall be entitled to a prompt report from an attending physician, diagnosis and prognosis, but (not including) NEED NOT INCLUDE an evaluation of disability in Workmen's Compensation Cases."

Respectively submitted,
ROBERT W. JOHNSON, 3RD, MD, *Chairman*
CONRAD ACTON, MD
JAMES G. ARNOLD, JR., MD
HOWARD F. KINNAMON, MD
J. ELLIOT LEVI, MD
F. FORD LOKER, MD
BELDEN R. REAP, MD
WILLIAM G. SPEED, 3RD, MD
JOHN F. STRAHAN, MD
JAMES D. DRINKARD, MD
PAUL HUFFINGTON, JR., MD
RUDIGER BRIETENECKER, MD

SELECT COMMITTEE ON FREE CHOICE, CLOSED PANEL AND HOSPITAL PROVISION OF MEDICAL SERVICES

Mr. President and Members of the House of Delegates:

The charge to this Committee is explained fully by its title. It was formed by the Council on June 9, 1966. It has had four meetings. The paucity of meetings was because of lack of adequate available information in connection with the proposals of the Johns Hopkins Medical Institutions to establish a medical program in the new community of Columbia City.

Previous Actions

The House of Delegates on September 18, 1959, adopted the report of the Faculty's Economics Committee. This report carried the statement as follows:

"Be it hereby Resolved, That the Medical and Chirurgical Faculty of Maryland goes on record as disapproving the concept of 'Closed Panel Practice of Medicine', when the patients themselves contribute by payment of premiums, assessments, dues or in any financial manner (whatever it may be called) and

"Be it further Resolved, That the Medical and Chirurgical Faculty stands committed to the concept of Freedom of Choice of Physician, and

"Be it further Resolved, By this action the Medical and Chirurgical Faculty stands opposed to any form of Closed Panel Practice of Medicine, where the patient is contributing financially to its support, and

"Be it further Resolved, that the Medical and Chirurgical Faculty will not approve any prepaid insurance plan to which the patient contributes unless the Freedom of Choice of Physician is included."

In Dallas, Texas, in December 1959, the AMA House of Delegates reaffirmed the following statement:

1. "The American Medical Association believes that free choice of physician is the right of every individual and one which he should be free to exercise as he chooses."

2. "Each individual should be accorded the privilege to select and change his physician at will or *to select his preferred system of medical care*, and the American Medical Association vigorously supports the right of the individual to choose between these alternatives."

However, in order to clarify and strengthen its position on the issue of freedom of choice of physician, the House also adopted this additional statement which was submitted as a substitute amendment on the floor of the House:

3. "Lest there be any misinterpretation, we state unequivocally that the American Medical Association firmly subscribes to freedom of choice of physician and free competition among physicians as being prerequisites to optimal medical care. The benefits of any system which provides medical care must be judged on the degree to which it allows of, or abridges, such freedom of choice and such competition."

It is to be noted that this is slightly at variance with the position of the Faculty. Namely, that the patient may "select his preferred system of medical care."

Committee Activity

The Committee addressed itself to all current "closed panel" types of operation in this State, as well as any future types that were being planned. It sent a letter to all of these groups:

Group Health Insurance
Leisure World
Baltimore Transit
Eastern Industrial Clinic
Central Medical Center
Eastpoint Medical Center

requesting an opportunity to visit with them and discuss the procedures under which they operated as well as see, first-hand, the type of care that was being given to participants in their program. Replies were received from the Leisure World, Inc., which operates a medical facility at Olney, Maryland; and from the Eastern Industrial Clinic, Inc., Baltimore. Both accepted the suggestion of the Committee and offered examination of their operations without question. The Group Health of Washington, D.C. provided us with extensive printed literature and also offered to meet with Committee members to expand on the literature or answer any questions the Committee might have to ask. The Committee elected not to visit with such representatives because of its location in Washington, D.C., determining that it was outside of the Committee's jurisdiction, even though it served some Maryland residents.

No acceptances were received to our requests from the remainder of this list even though replies were expedited by registered mail, return receipt requested. We can only assume that they are not willing to have the quality of care and services offered open to examination by their peers.

The questionnaire used in the examination of the two operations visited was patterned after one used by the AMA's Commission on Medical Care Plans in 1958. This study led to the action of the AMA's House of Delegates in June, 1959, and reaffirmation of this action in December 1959. Both of the groups examined scored high and the Committee representatives are of the opinion that high-quality medical care is rendered to the recipients of services under these plans and that they fall well within the ethical requirements as laid down by the Faculty, as well as the American Medical Association.

Until such time as an opportunity to visit the remaining groups is made available to examine their operations first-hand, the Committee can only assume, as stated above, that the quality of care and services offered cannot be evaluated because of the lack of willingness on the part of the party or parties in charge of these operations.

Columbia Health Plan

As mentioned before, the paucity of meetings of the Committee was because of lack of available information on this proposed program to be operated through the facilities of the Johns Hopkins Medical Institutions.

It was not until May 10, 1967, that a copy of the proposal was received by the Faculty, although it is understood from personal comments as well as items in the press that the study and conclusions had been reached some time before by those responsible for the "feasibility study."

Basically, the report auggests that the following recommendations be adopted:

1. That the primary objectives of the project are: a demonstration of the delivery of comprehensive health services, research in health care, and the training of health personnel.
2. That the prepaid plan for comprehensive health care services be developed at Columbia for a population group of up to 100,000 persons, and offered to residents of the Columbia area on a voluntary participation basis.
3. That the primary physician concept in rendering comprehensive services be established at Columbia along with the development of such other specialty support as may be required either at Columbia or on the Baltimore campus, and further recognizing that properly trained and qualified physicians in primary contact with the patient deserve an academic and financial standing commensurate with those of other practicing specialists.
4. That the physicians and staff at Columbia be afforded full rank and privileges of full-time members of the faculty and staff of The Johns Hopkins University School of Medicine and The Johns Hopkins Hospital, with remuneration and fringe benefits to be determined by the Columbia health plan.
5. That fiscal self-sufficiency and responsibility be adopted for the project by the formal incorporation of a health plan at Columbia under whose jurisdiction health services would be provided by a medical group and a hospital on a site to be selected at a later date.
6. That the development of a satellite relationship of the Columbia project to The Johns Hopkins Medical Institutions be defined and developed, recognizing first, the need for a high degree of local autonomy of operations at Columbia under broad policies and standards of The Johns Hopkins Medical Institutions and second, the goal of producing as near as possible a self-sufficient community health demonstration facility at local level.
7. That The Johns Hopkins Medical Institutions recognize and accept a service responsibility on the Baltimore campus for such specialty, consultation, laboratory, X-ray, and beds and ancillary services to Columbia as may be defined to supplement comprehensive health services at Columbia.
8. That, in view of the fact that acute hospital facilities are not available in Howard County, the Columbia health plan give consideration to offering acute bed facilities to those local physicians who are interested and qualified to render such hospital care until such time that other facilities or arrangements are available.

An additional report prepared by the "Ad Hoc Committee on Community Medicine," composed of the Chiefs of the various departments at the Johns Hopkins Medical Institutions, made the following recommendations:

(1) That an affirmative decision be made to proceed with the development of the Columbia Project conditional upon the ability to finance the Project without a drain upon the resources of the Medical Institutions and without competition for potential Johns Hopkins capital funds.

(2) That, concurrently, steps be taken to develop more fully Comprehensive Health Care for appropriate areas of East Baltimore.

(3) That the administrative authorities of the Medical School and Hospital be requested to proceed forwith to implement the foregoing decisions.

Because of lack of adequate information we are placed in the position of making certain assumptions. The proposal would provide community services in Columbia City and the surrounding area. Physicians would provide these services from local clinics still to be erected. These physicians would be on a salary basis, employed either through The Hopkins or the Columbia Health Plan. They would be available on a 24-hour basis to those persons who participate in the program. The physicians who are practicing independently now or in the future would continue to do as they have in the past. Persons would join the plan on "a voluntary participation basis." This concept falls within that adopted by the American Medical Association in December 1959. However, it is not clear as to how the plan would be financed, nor how much the annual premium would be.

In the initial discussion of the proposal, it was stated that the cost would be around $500. or $600. per family, per year. In our present economy most employers pay all or part of the Health Insurance premiums of its employees. This is usually done on a "group" basis. No indication is given in the Hopkins proposal as to how an employer would make payments to a separate health care program for some of his employees. Would any balance not paid by the subscriber or employer be underwritten by a Foundation, the Federal Government or some other type of organization who was willing to subsidize a new program on an experimental basis?

Besides subsidization, the question is raised as to the types of family who would be willing and anxious to enroll in such a program with such a high cost for premiums. It is possible that the person who has a large family or the person who is currently suffering from lengthy or multiple illnesses might be the only ones willing to pay this premium.

The plan also proposes that, pending the completion of hospital facilities in Columbia, the patients would utilize the services available at the John Hopkins Hospital for things such as X-ray, laboratory, consultation, etc. This pre-supposes the willingness of the patient to travel from Columbia, past several outstanding facilities with similar services, all the way to the Johns Hopkins Hospital. It also pre-supposes the patients willingness to travel to

Baltimore when he may well be Washington-oriented. In addition. it precludes the opportunity for the patient to select his own consultant or service facility.

In the areas of availability of such facilities, there now does not exist sufficient beds for private patients at the Johns Hopkins Hospital. In addition, the outpatient facilities are already overburdened. In this case, the Johns Hopkins Hospital is adding another load to already overtaxed services.

Within the medical staff of the institution, itself, there is dissent because private physicians are now unable to obtain beds for their private patients. St. Agnes Hospital already operating a brand-new facility of some 396 beds, in adding a new service facility. This institution now provides complete, modern and excellent facilities for all the health needs of the area it serves.

It is well-known that individuals like to have a family physician, a person to whom they can turn in time of their medical needs. Under the proposal as advanced, it is our understanding that individuals designated as "primary physician" will be rotated to 'The Hopkins Medical Institutions,' from time to time, in order that they can participate in a continuing education program. How the patients of these physicians will accept this concept is not known. Will they resent the fact that they are "turned over" to another physician with whom they may or may not be compatible?

In the maternity programs operated by the Baltimore City Health Department great emphasis is placed on the necessity for the patient to see the same obstetrician each time she visits the clinic. This has resulted in considerable improvement in the return visits made by the patient. We do not believe that this concept can be ignored.

Many of the homeowners in Columbia City may be tranferred to other parts of the country. Many others living there will be renting appartments; indeed some already are. How do these people transfer to other health programs when they are forced to leave Columbia . . . do they have to go through another "waiting period" for prexisting conditions and for obstetrical benefits?

It is assumed that these points have been dismissed as "administrative details," and that the writers of both reports on Columbia have established certain principles to follow, letting the "administrative details take care of themselves."

Specific Comments on the Report

1. That the primary objectives of the project are: a demonstration of the delivery of comprehensive health services, research in health care, and the training of health personnel.

Comment: The delivery of comprehensive health services has been demonstrated in many places throughout the country. There is no particular need for any additional demonstrations of this type of service. Research in health care has been under way for many years and there is no pressing need for the expenditure of additional governmental or foundation funds to perpetuate something that has already been studied at great length. The training of scarce health personnel can best be accomplished where there are adequate facilities and supervision for it, namely, in medical institutions.

2. That the prepaid plan for comprehensive health care services be developed at Columbia for a population group of up to 100,000 persons, and offered to residents of the Columbia area on a voluntary participation basis.

Comment: We do not believe that, without costly subsidization, this type of program, offered to a group of residents on a "voluntary" basis can be self-supporting. We do not believe, either, that many of those living in Columbia will be able to persuade their employers of the necessity of separating them from other employees so as to pay a portion of the costs of their health care, as it is currently being done by most industries today.

3. That the primary physician concept in rendering comprehensive services be established at Columbia along with the development of such other specialty support as may be required either at Columbia or on the Baltimore Campus, and further recognizing that properly trained and qualified physicians in primary contact with the patient deserves an academic and financial standing commensurate with those of other practicing specialists.

Comment: We do not believe the distance from The Johns Hopkins Hospital will lend itself to easy consultations, referrals, or other use of the facilities there. There are closer referral facilities; as well as modern, up-to-date hospital beds nearby and we do not believe that the additional overcrowding of hospital beds and diagnostic facilities at The Johns Hopkins Hospital will work to the advantage of the patient, the hospital or to the profession.

4. That the physicians and staff at Columbia be afforded full rank and privileges of full-time members of the faculty and staff of The Johns Hopkins University School of Medicine and The Johns Hopkins Hospital, with remuneration and fringe benefits to be determined by the Columbia health plan.

No Comment.

5. That fiscal self-sufficiency and responsibility be adopted for the project by the formal incorporation of a health plan at Columbia under whose jurisdiction health services would be provided by a medical group and a hospital on a site to be selected at a later date.

Comment: We believe that subsidization is necessary for any such proposal as this. We do not believe, because existing facilities and plans are currently available, that governmental or foundation funds should be used for the subsidization of a program of this nature.

6. That the development of a satellite relationship of the Columbia project to The Johns Hopkins Medical Institutions be defined and developed, recognizing firest, the need for a high degree of local autonomy of operations at Columbia under broad policies and standards of The Johns Hopkins Medical Institutions and second, the goal of producing as near as possible a self-sufficient community health demonstration facility at local level.

No Comment.

7. That The Johns Hopkins Medical Institutions recognize and accept a service responsibility on the Baltimore campus for such specialty, consultation, laboratory, X-ray, and beds and ancillary services to Columbia as may be defined to supplement comprehensive health services at Columbia.

Comment: We do not believe that overcrowding of already existing facilities is of any benefit to the public, the patient, the hospital or the profession.

8. That, in view of the fact that acute hospital facilities are not available in Howard County, the Columbia health plan give consideration to offering acute bed facilities to those local physcians who are interested and qualified to render such hospital care until such time that other facilities or arrangements are available.

Comment: We presume this refers to local physicians already practicing in Howard County. We do not believe that such physicians are anxious or willing to face the lengthy journey to The Johns Hopkins Hospital to see or visit their patients there, especially when adequate, up-to-date facilities are already available to them much closer than Hopkins.

We do believe, however, that the upgrading of the physical facilities at The Johns Hopkins Hospital are long overdue. While the hospital has assumed the medical responsibilities for those individuals in its general area, these responsibilities are not being discharged as effectively as they might. The Federal Government, under Title II of the Medicare Act, has provided some $1,200,000 to assist the Hopkins in this area. Much more needs to be done.

We believe that The Johns Hopkins Medical Institutions should bend its efforts to improvement of its facilities and plant so as to better serve those patients it is now serving. In addition, we believe that to attempt the development of a "Prepaid Group Practice Comprehensive Health Services at Columbia" would strain the resources available to The Johns Hopkins Medical Institutions and dilute the efforts now being made to provide first-class, high quality medical care to those individuals it is now serving and those it should provide services for in the East Baltimore area.

The Committee, therefore, recommends reaffirmation of the policies adopted by the House of Delegates in September 1959, and in the policy adopted by the AMA House of Delegates in December 1959.

Respectively submitted,
B. Martin Middleton, MD, *Chairman*
Manning W. Alden, MD
Wolcott L. Etienne, MD
Thomas F. Herbert, MD
Robert C. Kimberly, MD
Christian S. Mass, MD
Edmond J. McDonnell, MD
Belden R. Reap, MD
Peter V. Thorpe, MD

EX-OFFICIO MEMBERS: Richard D. Bauer, MD, Arthur G. Siwinski, MD, Karl F. Mech, MD, William A. Pillsbury, MD, J. Morris Reese, MD, Samuel Friedman, DDS.

PLEASE BRING THIS COPY WITH YOU TO THE MEETING

REFERENCE COMMITTEE REPORT

House of Delegates, Medical and Chirurgical Faculty of the State of Maryland
Semiannual Meeting, September 1967

Mr. President and Members of the House of Delegates:

Your Reference Committee met on Wednesday, August 23, 1967, to consider the one resolution introduced before July 15, 1967, the established deadline for introduction of resolutions. Members of the Faculty were notified of the meeting date of the Committee through the Executive Secretary's Newsletter in the July issue of the Maryland State Medical Journal. In addition, all members of the Faculty were notified in a letter, along with other information, under the date of August 2, 1967.

RESOLUTION 18/67

Submitted on:	May 26, 1967
Introduced by:	Prince George's County Medical Society
Subject:	Authorizing the seeking of enabling legislation to require compulsory membership in a component medical society of the Faculty in order to maintain high professional and ethical standards incident to the right and privilege of practicing medicine in Maryland

Whereas, Dynamic changes have taken place affecting the private practice of medicine by special privilege groups such as large corporations, insurance companies and trade unions, and
Whereas, The traditional physician-patient relationship is being threatened by various mass medical plans, and
Whereas, Organized medicine is being blamed and accused for the errors and shortcomings of mass medical plans, and
Whereas, Organized medicine is presently without the power to control said mass medical-care plans, now, therefore, be it
Resolved, That the Medical and Chirurgical Faculty of the State of Maryland seek enabling legislation to require compulsory membership in a component medical society of the Medical and Chirurgical Faculty in order to maintain high professional and ethical standards incident to the right and privilege of practicing medicine in the State of Maryland.

This resolution is identical to one introduced and discussed at the 1959 Annual Meeting. The Reference Committee Report contained remarks which are as valid today as they were in 1959. We believe they are worth repeating.

"This resolution raises moral and ethical problems which must not be treated lightly. Any move in our Society toward this goal must be taken only after the most careful thought relative to the legal and moral issues involved. Precedent should be investigated; the help of our own and the AMA legal department should be elicited; providing we can settle in our own minds affirmatively this one basic question, 'Should we attempt to legislate out of the practice of medicine a certain minority of physicians who differ with the rest of us about these basic problems?'

"The resolution being considered is vague as to what 'errors and shortcomings' and 'mass medical plans' specifically mean. The line cannot be clearly drawn, in some instances, between what is acceptable and not acceptable to us. As the matter now stands some honest differences in opinion do occur. The A.M.A. is now attempting to revamp and modernize sit own opinion by polling component societies in regards to these matters.*

"Would we not, in effect, be establishing a closed shop union; the very thing for which we criticize organized labor? Proponents of the resolution would state we must fight fire with fire and present a solid front to other organizations. Opponents would ask, do the means justify the end?

"The adoption, or disapproval of this resolution, must not be hasty or ill-advised."

*In Dallas, Texas, in December 1959, the AMA House of Delegates reaffirmed the following statement:

> 1. "The American Medical Association believes that free choice of physician is the right of every individual and one which he should be free to exercise as he chooses."
> 2. "Each individual should be accorded the privilege to select and change his physician at will or to select his preferred system of medical care, and the American Medical Association vigorously supports the right of the individual to choose between these alternatives."
>
> However, in order to clarify and strengthen its position on the issue of freedom of choice of physician, the House also adopted this additional statement which was submitted as a substitute amendment on the floor of the House:
>
> 3. "Lest there be any misinterpretation, we state unequivocally that the American Medical Association firmly subscribes to freedom of choice of physician and free competition among physicians as being prerequisites to optimal medical care. The benefits of any system which provides medical care must be judged on the degree to which it allows of, or abridges, such freedom of choice and such competition."

The Reference Committee at that time recommended that action be deferred on this resolution for further discussion, legal advice and precedent to be obtained with the results of these findings to be sent to each component society. The House of Delegates, however, voted that this be referred to the Policy and Planning Committee, for a report to be made to the Semiannual Session.

Following this, the Policy and Planning Committee met in June, 1959, considered this matter and recommended the following motion to the House of Delegates:

"That the House of Delegates, through the Council, reject the Prince George's County resolution as written; and that the Faculty work for legislation which would require the Medical and Chirurgical Faculty approval of all non-profit health plans or any changes thereto, before they can become effective."

This recommendation was adopted by the House of Delegates, after endorsement by the Council.

It is interesting to note that the Maryland Bar Association has recently had this problem under study. In 1966, at its Annual Session, it endorsed the principle of a requirement that attorneys be a member of the State Bar Association before being permitted to practice law in Maryland. Appropriate legislation was introduced at the 1967 session of the General Assembly. It passed the Senate but was held in the House Judiciary Committee for further study by the Legislative Council, which is currently taking place. It is understood that the objections to this proposal rise not from compulsory membership but from a requirement in the legislation that the Maryland Court of Appeals would act, in a sense, as the governing body of the State Bar Association. The Legislature apparently felt the profession should govern itself. The unified bar is not new. It exists in 27 states and two possessions.

Our investigation further reveals that the United States Supreme Court has held that such type of compulsory membership is constitutional.

The Membership Committee of the Faculty considered Resolution 1S/67, at its meeting on Wednesday, August 16, 1967, and after due consideration felt that the proposal as submitted was premature at this time and that the Commission on Medical Discipline will answer some of the reasons put forth for the adoption of Resolution 1S/67.

A majority of those present at the Reference Committee hearing spoke in opposition to the Resolution.

While the Faculty's House of Delegates has under consideration proposed changes in the Medical Practice Act, as recommended by the Ad Hoc Committee to Consider Changes in the Medical Practice Act, all of which would provide stronger disciplinary powers over both members and non-members of the Faculty than now exist, there remains much to be done.

The Committee favors the principle of the Resolved but finds the various Whereases somewhat confusing. Because of this, the Reference Committee, therefore, recommends that Resolution 1S/67 be postponed indefinitely, with the hope that at some future date a resolution with a similar objective will be introduced.

Your Reference Committee wishes to thank those who helped in its deliberations and to the staff who assisted in the preparation of this report.

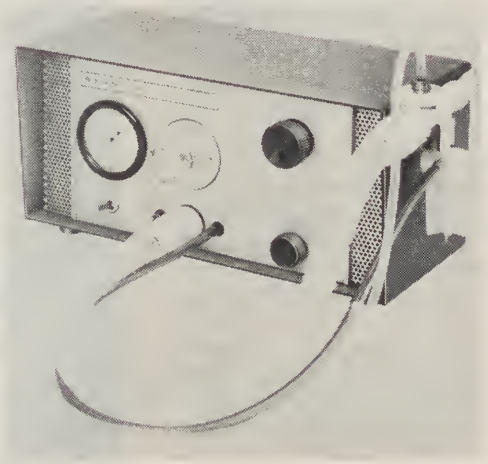
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Herbert H. Leighton MD
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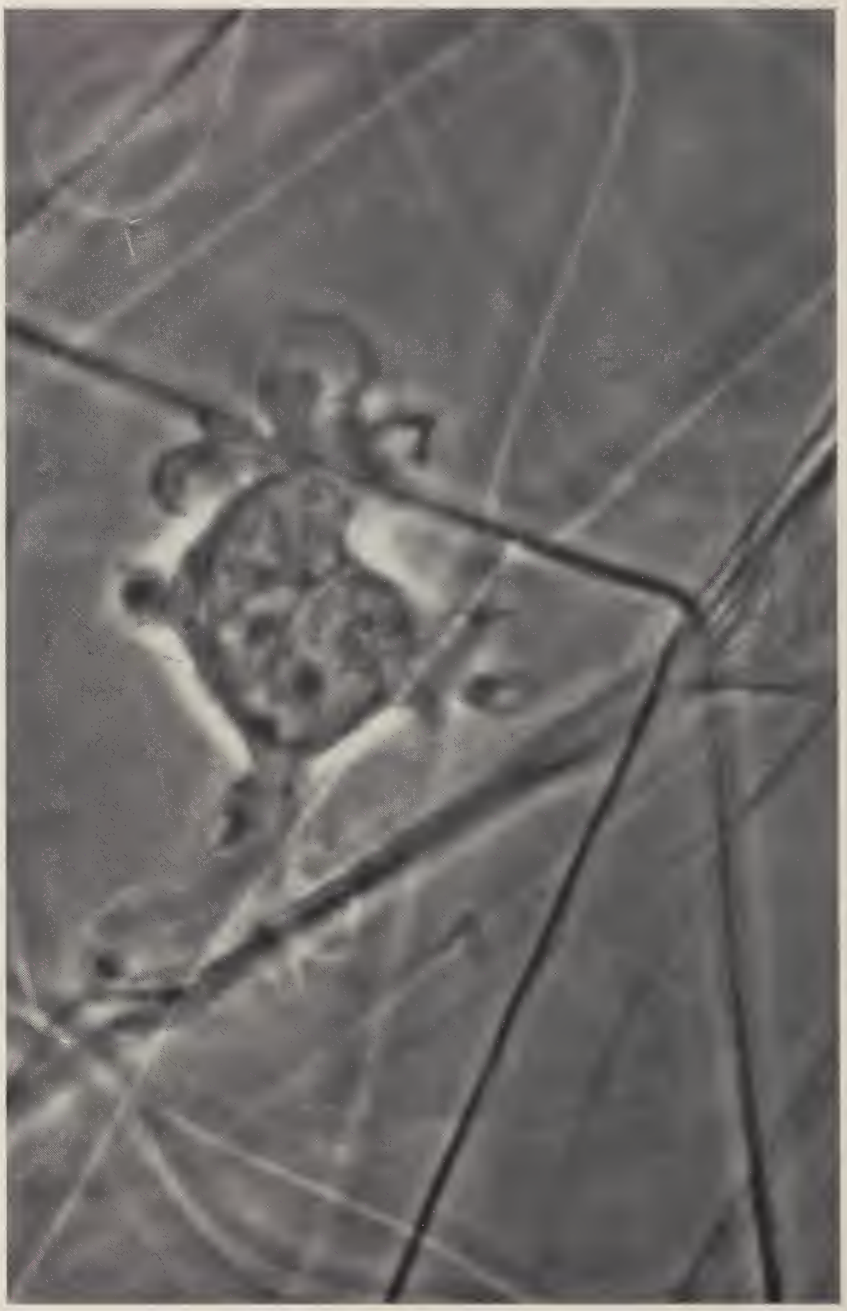
·ASCO·

INFLAMMATION:
A cellular fight for life

A SYNTEX REPORT based on recently developed hypotheses about topical corticosteroids, including the cellular theories of inflammation by Thomas F. Dougherty, Ph.D., University of Utah.

You are looking at a fibroblast fighting for life. This cell—one of the most common found in connective tissue—has literally been poisoned by cytotoxins released from other cells that have ruptured. Soon, if the abnormal activity of this fibroblast does not cease, it, too, will rupture and die—one more casualty in the inflammatory wave of destruction precipitated by injury.

Until a short time ago no one had ever witnessed such a scene at the cellular level. Now, through advanced cinemicrographic techniques, it is possible to view and photograph the inflammatory process as produced experimentally in living animal tissue. This method permits new insight into the mechanism of inflammation and the role of corticosteroids in therapeutic management. Equally important, these techniques shed new light on factors that may make one corticosteroid more effective than another—factors that can be correlated with other chemical, biologic, and clinical parameters.

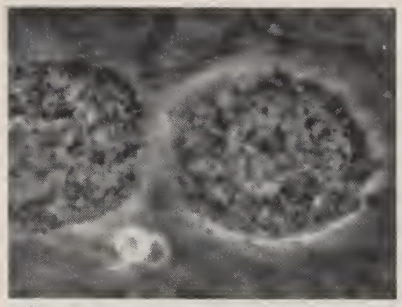


Visual evidence of how corticosteroids influence the inflammatory reaction

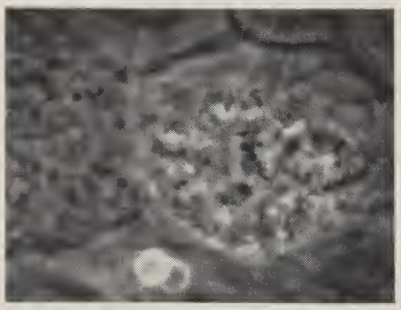
Working with phase-contrast cinemicrography on living animal tissue, Doctors Thomas F. Dougherty and David Berliner of the University of Utah College of Medicine have actually filmed cellular events that occur during the inflammatory reaction. This remarkable study* and additional work by these investigators, as well as by others, have established a new theoretical biologic basis for the antiinflammatory effect of the corticosteroids. (It must be noted that other theories, such as the lysosome or so-called "suicide bag" theory, have been postulated, although it is quite likely that there are more similarities than differences among the various theoretical models.)

The inflammatory wave of destruction

In this investigation an injurious injection of gelatin is used to set off an inflammatory reaction in living mouse tissue. What follows is a wave of destructive cellular activity that comprises the inflammatory response to injury. Mast cells (which contain heparin, serotonin and histamine) take up water, swell and rupture, releasing their contents, which are toxic outside the mast cell wall. These toxins, in turn, cause disintegration of other cells (such as fibroblasts) and the release of additional toxic material. Capillaries, too, take up water and leak unformed blood elements, causing edema. And polymorphonuclears, lymphocytes and perithelial cells invade the inflamed site. As a result of all these changes, the cellular environment reaches a state of turmoil.



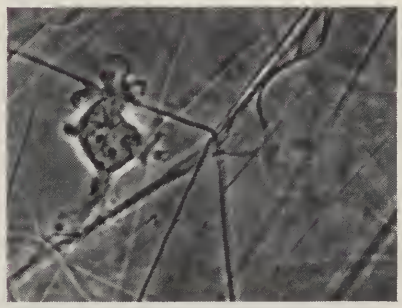
Phase-contrast microscopy showing mast cell before injury.



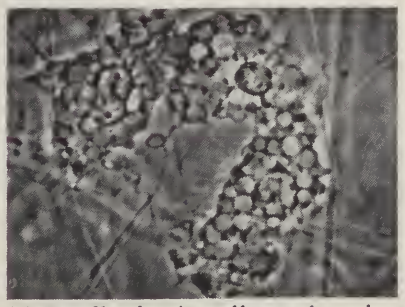
Mast cell (after injury) has broken up and released cytotoxins.

How corticosteroids change the picture

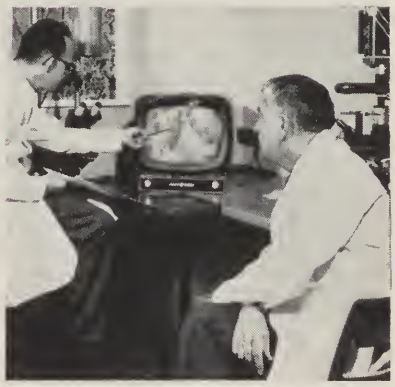
Corticosteroids appear to virtually stop the abnormal cellular activity that constitutes the inflammatory reaction. This permits the body's natural resources to clear up the inflamed area and repair the damaged tissue. This interpretation is supported by the fact that when the injurious gelatin solution is injected simultaneously with a corticosteroid – Synalar (fluocinolone acetonide) – the inflammatory pattern simply does not develop.



Fibroblast in high state of activity, much distorted.



Mast cells showing effects of corticosteroid action: cells are normal in size, shape and activity.



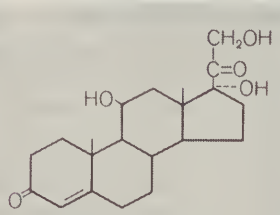
In summarizing his study Doctor Dougherty states: "...we also feel this work may explain why one corticosteroid helps a patient more rapidly and effectively than another. If it does, it is because one corticosteroid is the fastest, most effective inhibitor of the series of inflammatory events at the tissue level."

A New View of Corticosteroid Action in Inflammatory Dermatoses, a film based on this study, is now available from your Syntex representative.

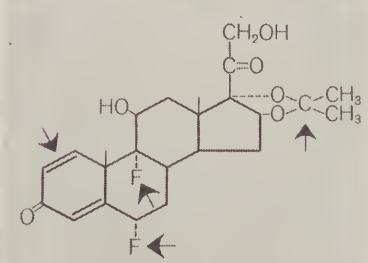
See last page for contraindications, precautions, side effects and dosage.

How advances in chemical design have achieved greater steroid potency

The chemical modification of corticosteroid molecules from the advent of hydrocortisone to the development of Synalar (fluocinolone acetonide) is a prime example of how biochemists can "design" to increase therapeutic activity and minimize undesirable side actions. Below, for example, we see the important changes that were made in reference to the hydrocortisone molecule to produce fluocinolone acetonide, one of the most active of all topical corticosteroids. As a result, a 0.01% preparation of Synalar (fluocinolone acetonide) has been reported to do the work of a 1% hydrocortisone product containing 100 times more cortiscosteroid. And it can often do it more effectively.



Hydrocortisone

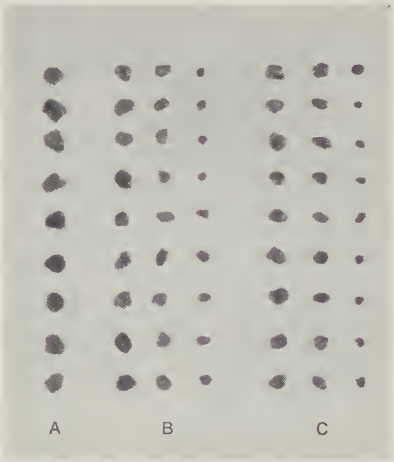


Fluocinolone Acetonide (Synalar)

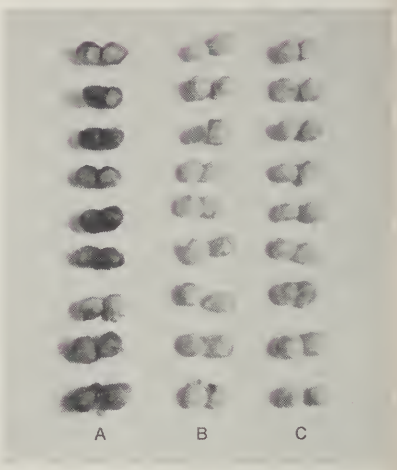
- *a double bond between carbons 1 and 2*
- *fluorine substitutions at* both *the 6-α, and the 9-α positions*
- *the addition of the acetonide at the 16-α, 17-α positions, thus providing one of the most potent topical corticosteroids available.*

How bioassay tests are used to "predict" therapeutic potential

Biologic assays are another tool used by researchers to help establish the relative activity of corticosteroids. To date no single method of assaying corticosteroid activity has emerged as the ideal "yardstick" for predicting therapeutic potential. Taken together, however, these methods have proved useful. When such tests are run on various corticosteroids, a definite order of corticosteroid activity becomes evident. Compounds with the highest order of activity may be expected to merit clinical trial to establish their high therapeutic potential. When assayed by these methods, fluocinolone acetonide (Synalar) emerges as one of the most active topical corticosteroids, milligram for milligram, available for clinical application today.



THE THYMUS INVOLUTION ASSAY[1-4] is run on adrenalectomized rats. The sizes of the glands are measured, and the degree of involution caused by the steroid is determined as an indication of its potency. In the above photo, the comparative involution of thymus glands achieved with hydrocortisone and Synalar (fluocinolone acetonide) is shown. Untreated controls (A) show normal size. Group B—injected with 1, 2 and 4 mg. of hydrocortisone—show progressively smaller thymuses as does Group C—injected with fluocinolone acetonide—but with only 1/500th the dose of hydrocortisone.



THE ANTIGRANULOMA ASSAY[1-4] also utilizes adrenalectomized rats. Granulomas are induced by subcutaneous implantation of cotton pellets on either side of the thorax. The degree of granuloma inhibition achieved by a steroid reflects its potency. The above photo shows the inhibition of granuloma formation achieved with hydrocortisone and Synalar (fluocinolone acetonide). Untreated controls (A) show large, red granulomas adhering to the pellets. Group B, receiving hydrocortisone and Group C, receiving fluocinolone acetonide, show little, if any, granuloma formation. Fluocinolone acetonide produced the same effect as hydrocortisone with only 1/500th the dose. This assay, as well as the thymus involution assay, measures systemic rather than topical corticosteroid activity. Nevertheless, results by these methods correlate well with other assays and with the milligram potencies of topical steroids in current clinical use.

Worldwide clinical experience confirms the predictable therapeutic potential of Synalar

It is particularly gratifying that the promise of the advanced chemical design and high order of bioassay activity of Synalar (fluocinolone acetonide) has been confirmed by widespread therapeutic application. Indeed, the impressive clinical response rate of Synalar has been documented in no fewer than 232 papers from 22 countries.

Representative Clinical Results with Synalar*

Efficacy Documented in over 4,000 Patients

Condition	Number of Publications	Number of Patients	Significant Improvement†
Contact Dermatitis	27	750	713
Eczematous Dermatitis	21	472	409
Seborrheic Dermatitis	18	442	426
Atopic Dermatitis	24	460	426
Psoriasis	36	1,699	1,510
Neurodermatitis	18	351	324
Total	144	4,174	3,808

*Complete bibliography on request.

†Expressed by the authors as excellent, very good, good, complete remission of inflammation, etc.

PRESCRIBING INFORMATION

For initiation of therapy: Cream 0.025%, 5 and 15 Gm. tubes, 425 Gm. jars; *for emollient effect:* Ointment 0.025%, 15 Gm. tubes; *for maintenance therapy:* Cream 0.01%, 15 and 45 Gm. tubes, 120 Gm. jars; *for intertriginous or hairy sites:* Solution 0.01%, 20 cc. and 60 cc. plastic squeeze bottles; *for infected inflammatory dermatoses:* Neo-Synalar® Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes.

CONTRAINDICATIONS: Tuberculous, fungal, and most viral lesions of the skin, (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. PRECAUTIONS: Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. When severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. SIDE EFFECTS: Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. The neomycin in Neo-Synalar Cream rarely produces allergic reactions.

REFERENCES: 1. Lerner, L. J., Bianchi, A., Turkheimer, A. R., Singer, F. M., and Borman, A.: Anti-inflammatory steroids: potency, duration and modification of activities. Ann NY Acad Sci 116:1071 (Aug. 27) 1964. 2. Idem: Comparison of anti-granuloma, thymolytic and glucocorticoid activities of anti-inflammatory steroids. Proc Soc Exp Biol Med 116:385 (June) 1964. 3. Ringler, A.: Activities of adrenocorticosteroids in experimental animals and man, in Dorfman, R. I.: Methods of hormone research, New York, Academic Press, 1964. vol. III. pp. 234-280. 4. Gubersky, V. R.: To be published.

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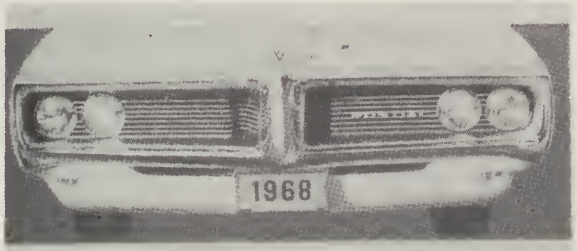
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Milligram for milligram one of the most active topical corticosteroids available

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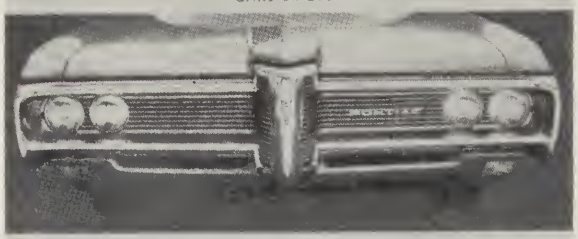
Results often comparable to those of systemic corticosteroids with fewer hazards



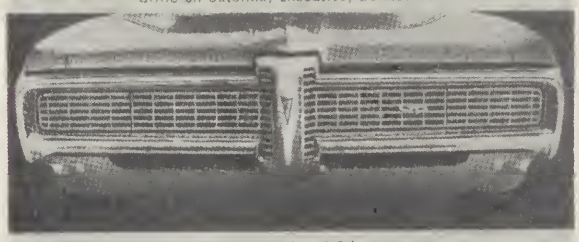
Grille on Tempest, Tempest Custom, Le Mans and Tempest Safari



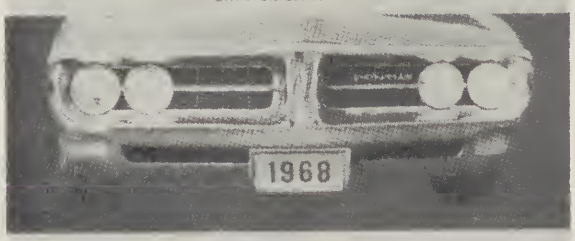
Grille on GTO



Grille on Catalina, Executive, Bonneville



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BUSINESS SESSIONS

SEPTEMBER 8, 1967

SEMIANNUAL MEETING

MINUTES

The 258th meeting, semiannual session, of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland was called to order at 9:35 a.m., Friday, September 8, 1967, at Ocean City, Maryland, the President and Secretary being present.

The following delegates (or alternates) were registered as being in attendance. The asterisk indicates an alternate delegate:

Doctors: Manning W. Alden, Council; Robert G. Angle, Montgomery County; Timothy D. Baker, Baltimore City; *Charles Bagley, III, Wicomico County; John G. Ball, Montgomery County; Edward M. Barczak, Baltimore City; Richard D. Bauer, Council; J. Howard Beard, Council; Harry McBrine Beck, Baltimore City; M. McKendree Boyer, Past President; *Donald L. Bucy, Montgomery County; *Albert E. Bunker, Dorchester County; Wendell J. Burkett, Kent County; Read N. Calvert, Montgomery County; Douglas G. Carroll, Baltimore City; Robert G. Chambers, Baltimore City; *Katherine A. Chapman, Montgomery County; Henry V. Chase, Council; *Shirley R. Clinton, Baltimore City; Archie R. Cohen, Council; H. Douglas Cooper, Wicomico; Worth B. Daniels, Baltimore City; Melvin B. Davis, Baltimore County; John B. De Hoff, Baltimore City; DeWitt E. DeLawter, Montgomery County; J. Sheldon Eastland, Council; William Carl Ebeling, Council; *Max R. English, Baltimore City; Vincent J. Fiocco, Carroll County; Russell S. Fisher, Council; *William E. Gilmore, Baltimore City; *Paul F. Guerin, Baltimore City; William B. Hagan, Council; William G. Helfrich, Baltimore City; Thomas F. Herbert, Howard County; Philip W. Heuman, Harford County; Frederick M. Johnson, Charles County; Ferd E. Kadan, Baltimore City; James R. Karns, Baltimore City; Lauriston L. Keown, Baltimore City; Robert C. Kimberly, Council; Howard F. Kinnamon, Past President; Edward L. J. Krieg, Baltimore County; Henry P. Laughlin, Council; C. Rodney Layton, Queen Anne's County; Herbert H. Leighton, Garrett County; *Leon Levitsky, Prince George's County; Norman Levin, Baltimore City; William J. McClafferty, Baltimore City; *Charles B. Marek, Baltimore City; Karl F. Mech, Council; B. Martin Middleton, Council; *Benjamin S. Miller, Prince George's County; John E. Miller, Baltimore City; Donald W. Mintzer, Baltimore City; Frank K. Morris, Board of Medical Examiners; Frederick E. Musser, Prince George's County; *James J. Nolan, Baltimore City; Clayton Norton, Anne Arundel County; Charles F. O'Donnell, Council; Hilary T. O'Herlihy, Anne Arundel County; A. Austin Pearre, Past President; William A. Pillsbury, Jr., Council; *Carolyn S. Pincock, Montgomery County; Belden R. Reap, Sr., Montgomery County; J. Morris Reese, Council; Guy M. Reeser, Jr., Talbot County; Thomas R. Reid, Frederick County; *James A. Roberts, Montgomery County; Donald J. Roop, Council; Salvador Rossello, Baltimore City; Edwin Ruzicka, Talbot County; Emmanuel Schimunek, Baltimore City; Arthur G. Siwinski, Council; Thaddeus C. Siwinski, Baltimore County; R. Kennedy Skipton, Prince George's County; Aaron C. Sollod, Baltimore City; William G. Speed, III, Council; Omar D. Sprecher, Jr., Washington County; Martin E. Strobel, Baltimore County; E. L. Suarez-Murias, Baltimore City; Francis J. Townsend, Jr., Council; Harry R. Trapnell, Caroline County; Thomas E. Van Metre, Jr., Baltimore City; Merton T. Waite, Anne Arundel County; Emerson C. Walden, Baltimore City; Hugh W. Ward, Calvert County; *Howard N. Weeks, Washington County; J. Arthur Weinberg, Council; William C. Weintraub, Prince George's County; Lawrence R. Wharton, Jr., Baltimore City; Charles H. Williams, Baltimore County; Donald O. Wood, Baltimore County; Arthur O. Wooddy, Council; Charles E. Wright, Frederick County; John D. Young, Jr., Baltimore City; and Raymond M. Yow, Council.

Present also for the meeting were staff personnel.

INVOCATION

The invocation was given by Donald W. Mintzer, MD, Chairman of the Faculty's Subcommittee on Medicine and Religion.

The President made certain announcements with regard to the conduct of business at the session.

INTRODUCTION OF NEW DELEGATES

The President introduced the following new delegates who were present for their first session:

J. Howard Beard, MD, Second Vice-President
Arthur G. Siwinski, MD, President-elect
William G. Speed, III, MD, Council
Francis J. Townsend, MD, Third Vice-President

MINUTES

The minutes of the April 19 and April 21, 1967 meetings respectively of the House of Delegates, annual session, having been distributed to the members, and having been approved by the Executive Committee, were presented to the House for information.

MEDICOLEGAL COMMITTEE REPORT

Howard F. Kinnamon, Chairman of the Medicolegal Committee for 1966-67, on its behalf, moved adoption of the following amendment to the Medicolegal Code of

BREAK A DIET CYCLE, TODAY.

On-again, off-again dieting is the worst kind.

On the 8th day of most "7-day diets," people are too busy eating to tell you how much they lost.

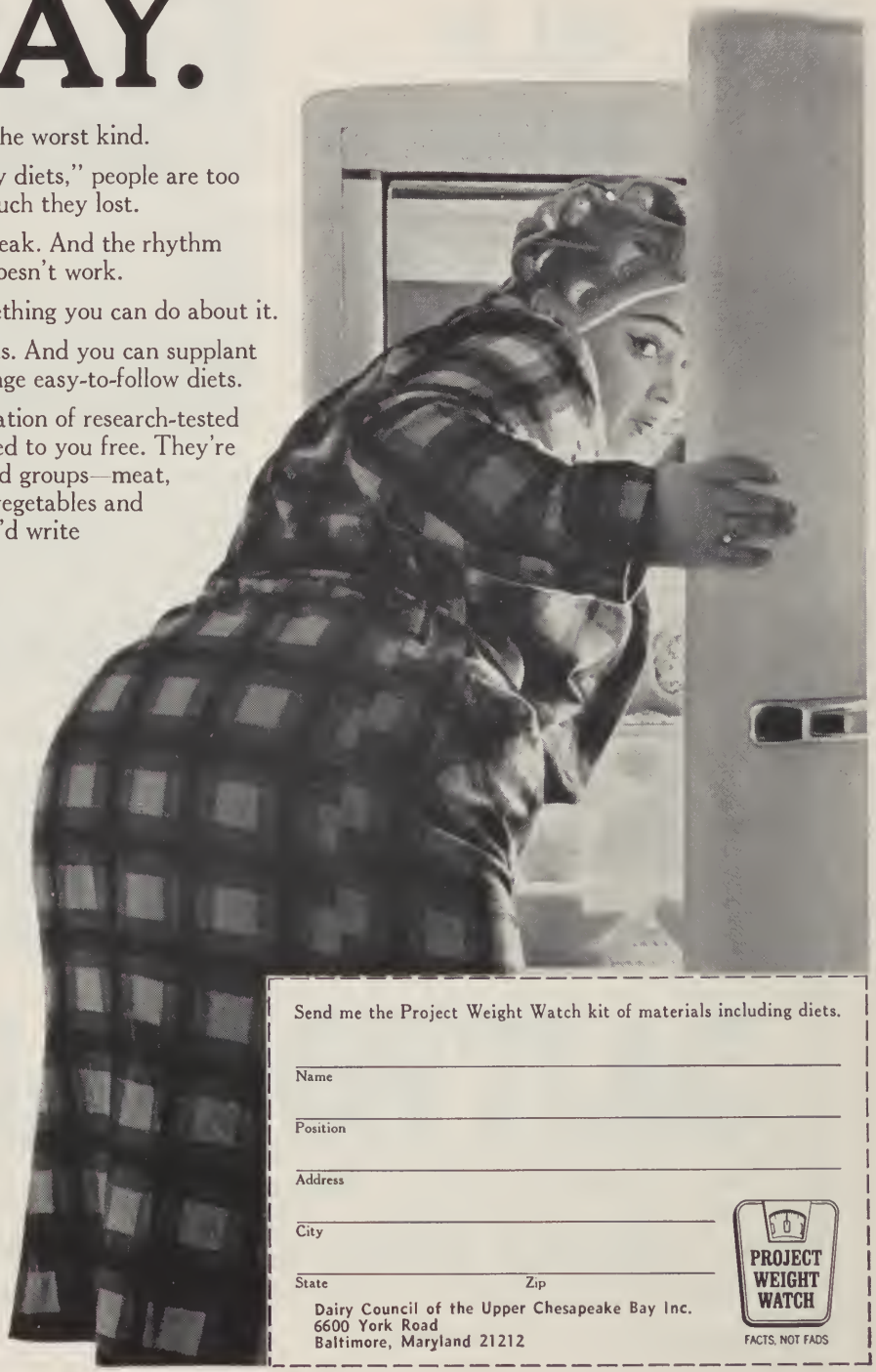
It's just that week diets are weak. And the rhythm method of girth control just doesn't work.

As a professional, there's something you can do about it.

You can replace fads with facts. And you can supplant short-term plans with long-range easy-to-follow diets.

That's what prompted preparation of research-tested scientific diets which are offered to you free. They're a realistic balance of the 4 food groups—meat, bread and cereals, fruits and vegetables and dairy foods. They're diets you'd write yourself if you had the time.

Send for them. Fasts are slow ways to lose weight.



Send me the Project Weight Watch kit of materials including diets.

Name

Position

Address

City

State Zip

Dairy Council of the Upper Chesapeake Bay Inc.
6600 York Road
Baltimore, Maryland 21212

PROJECT WEIGHT WATCH

FACTS, NOT FADS

Cooperation, such amendment having already been adopted by the Baltimore City Bar Association and the Maryland State Bar Association, which was adopted, after debate:

Amend the first sentence of paragraph 2 of the Medico-legal Code of Cooperation by substituting for it the following new sentence:

The patient, or his attorney, upon written request, when accompanied by a signed authorization from the patient shall be entitled to a prompt report from the attending physician containing the history, physical condition, diagnosis, and prognosis, but need not include an evaluation of disability in Workmen's Compensation Cases.

FACULTY DELEGATES TO THE AMA REPORT

The report of the Faculty's Delegates to the American Medical Association was filed. Russell S. Fisher, MD, acting on behalf of the Delegates, once again urged members to appear before Reference Committee meetings of the AMA House of Delegates to make their personal views known on any subject under discussion in the Committee.

PHYSICIAN/PHARMACIST CODE OF COOPERATION

William L. Stewart, MD, Liaison Committee Chairman, on behalf of the Committee moved adoption of the Physician/Pharmacist Code of Cooperation, which, after debate, was unanimously adopted.

BYLAWS COMMITTEE REPORT

Dr. O'Donnell, Bylaws Committee Chairman, on its behalf, moved the adoption of the following Bylaw amendments which, after debate, were adopted in each case by more than the required two-thirds vote:

(a) Amend Article III, Section 1, by adding:

"if they are not being collected through the facilities of the Faculty by the agreement between the Faculty and the Component Society."

(b) Amend Article VI, Section 4, by adding:

"Provided, however, that a resolution introduced by an individual member must have the endorsement of either one-third of the membership of his Component Society, or 30 members of his Component Society, whichever is smaller."

(c) Amend Article XI, Section 1, by striking out the entire section.

(d) Amend Article XI, Section 4, by striking out the entire section and substituting the following new section:

Section 4: A Medical Economics Committee of at least five members shall serve as a *Review Committee* for health insurance and other third party payors to determine equitable and just fees for procedures performed and for which such carriers are responsible. It may only act on the request of the carrier or patient or physician involved, and after the medical service has been rendered. It shall not determine the legal rights or benefits under such policies. It shall also be empowered to investigate, within the responsibilities and charges designated in these bylaws, areas of economic benefits for members of the Faculty. It shall receive the report of the Faculty's officially approved Professional Liability Program and shall prepare and present an educational program to physicians in this regard. Its chairman shall be appointed by the President and said chairman shall appoint the other members of the Committee with the approval of the President. The Baltimore City Dental Society shall have the right to elect one associate member of the Committee with voice but no vote.

(e) Amend Article XI, Section 5, by striking out the words, "and Business Manager"

(f) Amend Article XI, Section 7, by striking out "A Fee Schedule Committee to consider and advise the Faculty on all questions relating to Fee Schedules shall



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be composed of"

and substituting:

Section 7: "A Professional Medical Services Committee shall consider and advise the Faculty on all matters relating to the professional services provided to the public by members of the Faculty. It shall not conflict in any way with charges made in these bylaws to other committees of the Faculty. It shall make available facts, data and opinions with respect to timely and adequate rendition of medical care to the public; to investigate matters pertaining to the economics of medical practice and where related, social aspects of medical care; it shall study means for the distribution of medical service to the public consistent with the principles adopted by the Faculty's House of Delegates and the AMA's House of Delegates. It shall be composed of . . ."

(g) Amend Article XI, Section 11, by striking out the following:

Section 11: "A Liaison Committee of at least ten members shall provide from among its membership such liaison as is required on the following subjects: Veterans medical care, accreditation of hospitals, adoption and vocational rehabilitation, and to the following organizations: Bureau of Old Age and Survivor's Insurance, State Department of Health and Maryland Pharmaceutical Association."

and substituting the following:

Section 11: "A Liaison Committee of at least ten members shall provide from among its membership such liaison as is required with other professional organizations, such as but not limited to: Maryland Nurses Association, Maryland Pharmaceutical Association, State Department of Health, all specialty medical organizations in the state. It shall not conflict in any way with charges made in these bylaws to other committees of the Faculty."

(h) Amend Article XI, Section 13, by striking out the second sentence as follows:

Section 13: "This Committee shall meet with labor unions, professional organizations and others interested in improving the quality of medical care, for discussion and consideration of questions of mutual interest in this area."

(i) Amend Article XI, Section 18, by striking out the second sentence which reads:

Section 18: "It shall serve in an advisory capacity to the State Accident Fund."

(j) Amend Article XI, Section 20, by striking out the following:

Section 20: ". . . subjects, among others: diabetes, geriatrics, maternal and child welfare, pelvic cancer, rural health, tuberculosis, prevention of automotive highway disasters, regulations relating to hospital licensing, immunizations and alcoholism."

and insert the following:

Section 20: ". . . postgraduate educational programs, any health topic or subject that is of general interest to Faculty members, all phases of medical education, public health matters and all aspects of preventive medicine and health maintenance. It shall not conflict in any way with charges made in these bylaws to other committees of the Faculty."

(k) Amend Article XIII, Section 3, in the second section, by striking out the word "Council" where it first appears in that sentence and inserting the word, "Committee."

EMERITUS MEMBERSHIP

On motion of the Chairman of the Council, the following members who had received the recommendation af the Council, were elected to Emeritus Membership:

Alexis M. Bagusin, MD, Baltimore City
E. Ross Davies, MD, Baltimore City
Earl E. Broadrup, MD, Allegany County
Arthur I. Fink, MD, Baltimore City



He leaves to make an urgent call But doesn't use the phone at all

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...soothes colicky pain with paregoric
...consolidates fluid stools with pectin
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warning: may be habit forming
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Artur Saar, MD, Baltimore City
Isadore M. Siegel, MD, Baltimore City
N. B. Steward, MD, Prince George's County
Arthur N. Tasker, MD, Baltimore City
Kenneth W. Taber, MD, Harford County

COMMISSION ON MEDICAL DISCIPLINE AD HOC COMMITTEE TO CONSIDER CHANGES IN THE MEDICAL PRACTICE ACT

John M. Dennis, MD, Chairman of the Ad Hoc Committee to consider changes in the Medical Practice Act, moved on behalf of the Committee that the report as presented be adopted. After lengthy debate, and while an amendment was pending to strike out "commission" and insert "Board of Medical Examiners" wherever it appears, a motion was made which, after debate and amendment, was adopted as follows:

"That the Report be recommitted to the same Ad Hoc Committee for further study in consultation with the Board of Medical Examiners so as to reconcile the differing views."

The President announced that, in accord with the views of the House, that a special meeting of the House of Delegates would be called under Article VI, Section 2, of the Bylaws in time for preparation and introduction of legislation for the 1968 state legislature.

REPORT OF THE SELECT COMMITTEE ON FREE CHOICE, CLOSED PANEL AND HOSPITAL PROVISION OF MEDICAL SERVICES

Dr. Middleton, on behalf of the Select Committee on Free Choice, Closed Panel and Hospital Provision of Medical Services, moved adoption of the following resolution; which was unanimously adopted:

Resolved, That the House of Delegates reaffirm its policies adopted on September 18, 1959, and the policy adopted by the House of Delegates of the American Medical Association in December, 1959, disapproving the concept of closed panel practice of medicine when the patient contributes financially to its support as an abridgement of the patient's freedom of choice of a physician."

REFERENCE COMMITTEE REPORT

Dr. DeLawter, on behalf of the Reference Committee, moved that Resolution 1S/67 be postponed indefinitely. After debate, the Resolution, the text of which follows, was postponed indefinitely:

Whereas, Dynamic changes have taken place affecting the private practice of medicine by special privilege groups such as large corporations, insurance companies and trade unions, and

Whereas, The traditional physician-patient relationship is being threatened by various mass medical plans, and

Whereas, Organized medicine is being blamed and accused for the errors and shortcomings of mass medical plans, and

Whereas, Organized medicine is presently without the power to control said mass medical care plans, now, therefore, be it

Resolved, That the Medcial and Chirurgical Faculty of the State of Maryland seek enabling legislation to require compulsory membership in a component medical society of the Medical and Chirurgical Faculty in order to maintain high professional and ethical standards incident to the right and privilege of practicing medicine in the State of Maryland.

ADJOURNMENT

Due to the lateness of the hour, those speakers who had announcements to make deferred to the wish of the House of Delegates which voted unanimously to adjourn, *sine die,* at 12:15 p.m.



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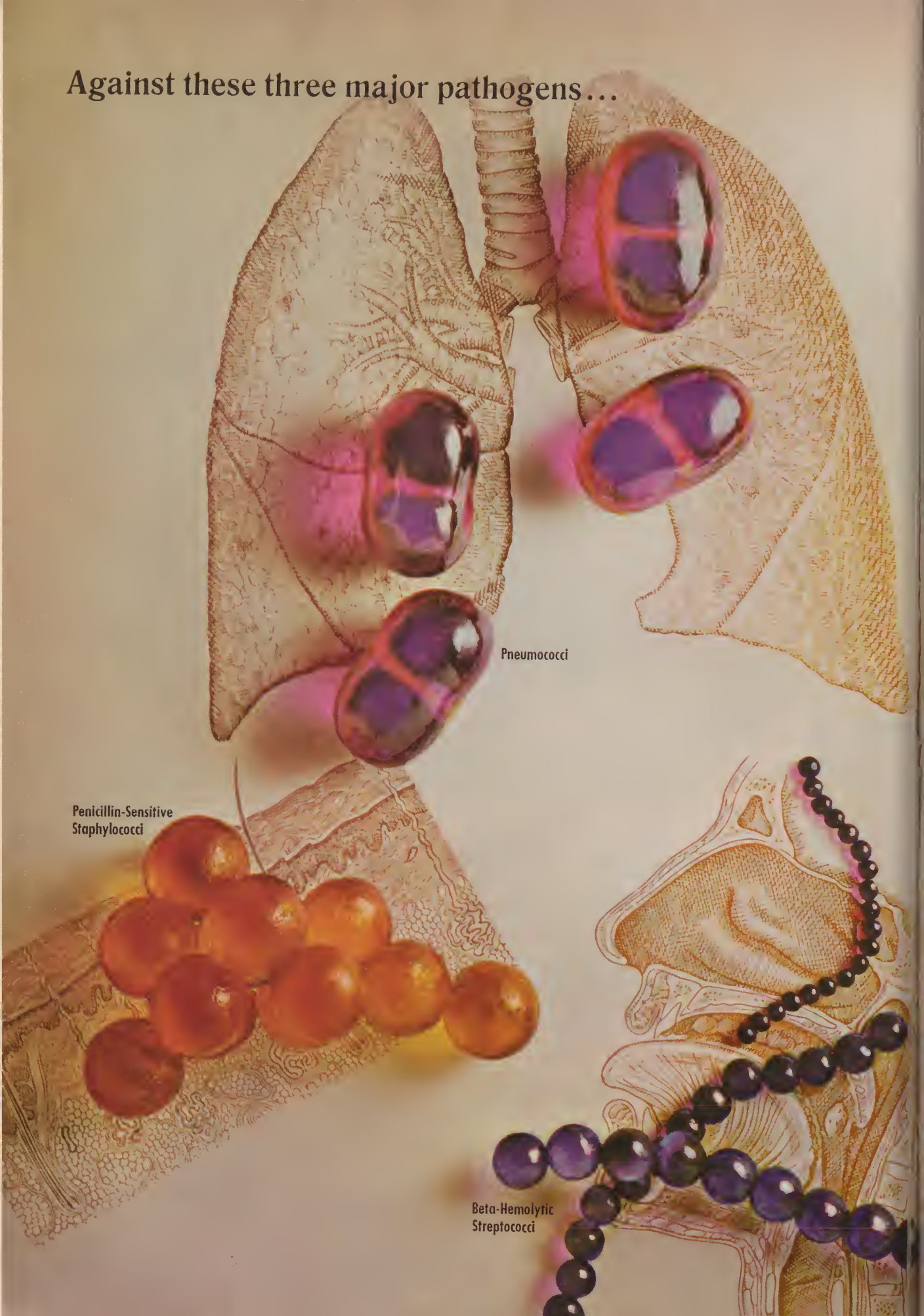
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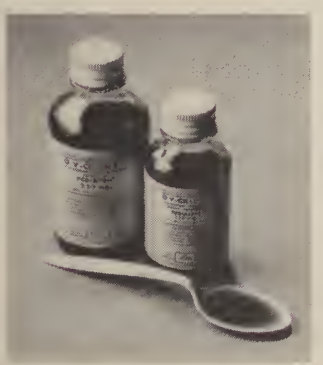
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V-Cillin K has been shown to be effective in the treatment of streptococcus and pneumococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy in patients with a history of rheumatic fever or congenital heart disease.

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Potassium Phenoxymethyl Penicillin

Now available: V-Cillin K®, Pediatric, for Oral Solution, 250 mg. (400,000 units) per 5 cc. of solution.

(See next page for prescribing information.)

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V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

Indications: V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Warnings: In rare instances, the use of penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin and in those with bronchial asthma or other allergies. Resuscitative drugs should be readily available for emergency administration. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for relief of immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of pencillin-insensitive organisms. In such cases, its administration should be discontinued, and appropriate measures should be taken.

Adverse Reactions: Although serious allergic reactions are much less common with administration of oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it does possess a significant index of sensitization. The following hypersensitivity reactions associated with the use of penicillin have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: For Tablets V-Cillin K and for V-Cillin K, Pediatric, the usual dosage ranges from 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, the daily dosage may be 50 mg. per Kg. of body weight divided into three doses.

Beta-hemolytic streptococcus infections without associated bacteremia may be treated with 200,000 to 400,0000 units three times a day. Therapy should be continued for a minimum of ten days to prevent development of rheumatic fever and/or other serious complications. Dosage for routine streptococcus prophylaxis in patients with a history of rheumatic fever or congenital heart disease may be 200,000 units once or twice daily. When such patients undergo tonsillectomy, tooth extraction, or other minor surgery, the prophylactic dose should be 500,000 units every six hours given two days prior to surgery and for two days postoperatively. If oral medication is not feasible on the day of surgery, parenteral therapy should be considered. Mild to moderately severe pneumococcus pneumonia has been treated effectively with 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be given every six to eight hours in conjunction with indicated surgical procedures.

For gonorrhea in males, 500 mg. (800,000 units) every four hours for three doses may be employed; in females, 500 mg. every four hours for six doses are recommended. Refractory infections generally respond to a second treatment three to four days following completion of the first. Treatment of gonorrhea with severe complications should be individualized, with prolonged and intensive treatment. Patients with a suspected lesion of syphilis should have a dark-field examination before receiving penicillin and monthly serologic tests for a minimum of three months.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units), in bottles of 50 and 100; and 250 mg. (400,0000 units) and 500 mg. (800,000 units), in bottles of 24 and 100.

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Indications: Osteoarthritis, rheumatoid arthritis, rheumatoid spondylitis, psoriatic arthritis, acute gout, painful shoulder (peritendinitis, capsulitis, bursitis and acute arthritis of that joint), acute superficial thrombophlebitis.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make regular blood counts. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ul-

For 280-lb. tackles—or 108-lb. housewives—Butazolidin alka can hasten recovery from the agonizing pain of shoulder bursitis.

It's not for every patient. Check carefully the Contraindications, Warning and Precautions shown below.

And adverse reactions may occur. The most common are nausea, edema and rash. Rarely, agranulocytosis has been reported. All adverse reactions are listed below, too.

Play-for-pay or workaday patients—when they come up with shoulder bursitis and your clinical judgment indicates Butazolidin alka—go with it.

And watch the comeback.



cer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Purpuric rash has also been reported. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been.reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur. 6509-V(B)R2

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Dosage in painful shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

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1968 ANNUAL MEETING

MEDICAL & CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

April 17, 18, 19 Alcazar, Baltimore
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IN BALTIMORE

Wednesday, April 17— 8:00 A.M.—Business Meetings of Specialty Societies
9:30 A.M.—Meeting of the House of Delegates
12:30 P.M.—"Quiz the Experts" Luncheon
2:15 P.M. to 4:30 P.M.—Scientific Session
8:15 P.M.—Theater benefit for AMA-ERF

Thursday, April 18— 9:30 A.M.—Medical Grand Rounds followed by a lecture
2:15 P.M.—Surgical Grand Rounds followed by a lecture
6:15 P.M.—Annual Presidential Reception and Banquet

Friday, April 19— 9:30 A.M. to 12 Noon—Scientific Session
2:00 P.M.—Meeting of House of Delegates

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Sun., April 21—Embarkation on board ship will be from 1:30 P.M. to 3:00 P.M. Sail from Baltimore at approximately 4:00 P.M.—a gourmet dinner will be your first meal aboard this luxurious liner.

Mon., April 22 and Tues., April 23—Two wonderful days of sailing with fun and games—sunning, swimming, entertainment, excellent food, and special business and scientific meetings.

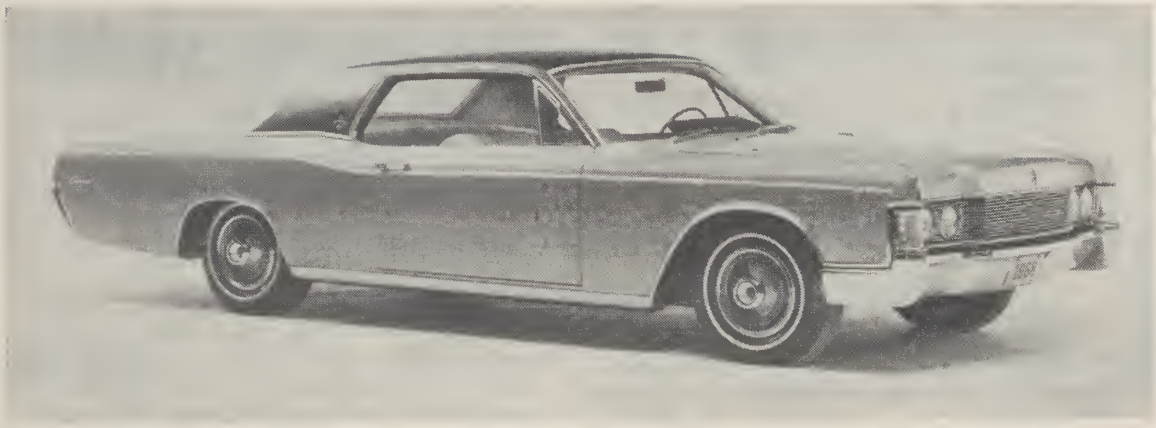
Wed., April 24—Arrive San Juan about 1:00 P.M.—sightseeing tours will be available to enjoy this tropical island.

Thurs., April 25—Sail from San Juan at 3:00 A.M. and arrive in St. Thomas at 9:00 A.M.—sightseeing tours will again be offered to see this charming island. Sail from St. Thomas about 4:00 P.M.

Sun., April 28—Arrive Baltimore in the afternoon about 2:00 P.M.
Business meetings and scientific sessions will be held daily aboard ship.

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MARYLAND ASSOCIATION OF MEDICAL ASSISTANTS

OCTOBER, 1967

Semi-Annual Meeting—Ocean City

The Maryland Association of Medical Assistants held its semi-annual meeting at the Ship's Cafe, Ocean City, Maryland on Saturday, September 9, 1967. Mrs. Nell Chaney, newly installed as President of the association presided. Mrs. Chaney is secretary to Socrates Kendros, MD, Director of Medical Education at Church Home and Hospital.

Registration began at 10:00 a.m. followed by the business meeting and lunch. An educational seminar was presented in the afternoon. Mrs. William B. Stone, President of the Woman's Auxiliary of the Medical and Chirurgical Faculty, welcomed all in attendance and spoke on the possibilities for liaison between the Medical Assistants and the Woman's Auxiliary, which so far has been neglected. Raymond M. Atkins MD, instructor in Clinical Anatomy at the University of Maryland and Chairman of the Emergency Room Department and Assistant Director of Medical Education at Church Home and Hospital, spoke on Emergency Room Care and Medico-Legal Problems. This was followed by a film on The Doctor Defendant, which was of great value to the medical assistant who must constantly be on guard against possible legal entanglements for herself and her employer. Mr. Thomas F. Horton, Marketing Manager for Ocean Research and Engineering Center, Westinghouse Corporation concluded the seminar with Oceanography And Undersea Exploration, a discussion of tremendous current interest, having to do with such science fiction subjects as undersea laboratories, minisubs, etc.



Raymond M. Atkins, MD, on left, and Jack M. Zimmerman, MD, on right.

Cocktail hour was at 6:30 at the Ship's Cafe, followed by the banquet at 7:30 p.m. The invocation was given by Reverend Thomas Subock, Methodist Minister of the Baltimore Conference, who resides near Annapolis, Maryland. Reverend Subock is the husband of one of the members of the Medical Assistants Association.

Jack M. Zimmerman, MD, Chief of Surgery at Church Home and Hospital and Associate Professor of Surgery at The Johns Hopkins Hospital was Master of Ceremonies.

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It is an anticholinergic drug without narcotic properties. Side effects are usually mild.

IN BRIEF: One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth, blurring of vision, constipation, nausea, vomiting, bloating and dizziness may occur but are usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy — withhold in glaucoma. Contraindicated in patients sensitive to phenobarbital and/or Cantil (mepenzolate bromide); in toxic megacolon, obstruction of G. I. or G. U. tract.

SUPPLIED: CANTIL (mepenzolate bromide) — 25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL — containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

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STATE OF MARYLAND

Department of Mental Hygiene

Isadore Tuerk, MD, Commissioner

Kurt Gorwitz, ScD, Statistics Director

The Hospitalized Adolescent

Last year more than 400 children between the ages of 12 and 17 were under care in Maryland's state mental hospitals. This is equal to one out of every 1,000 Maryland residents in this age group.

The following table shows the distribution of resident patients in this age group (as of July 1, 1966) by diagnosis, age and length of hospitalization. Half were diagnosed as transient situational personality disturbances, one out of six as psychotic and one out of ten as personality disorders. Although most were recent admissions, a number had been under continuous inpatient care for extended time periods.

The adolescents in state mental hospitals represent only a small proportion of those seen in psychiatric facilities. Data available through the Maryland Psychiatric Case Register indicate that 11.9 percent of all admissions 10-17 years of age were to state hospitals, 6.3 percent to other inpatient facilities, 56.1 percent to county operated clinics and 25.6 to other community centers. However, they do represent a major portion of those receiving treatment since many of the adolescent admissions to outpatient facilities are seen only for testing, evaluation and diagnosis.

AGE AND LENGTH OF HOSPITALIZATION	REPORTED DIAGNOSIS				
	TOTAL	PSYCHOTIC DISORDERS	PERSONALITY DISORDERS	TRANSIENT SITUATIONAL PERSONALITY DISTURBANCES	ALL OTHERS
12-14 Years of Age	81	13	8	47	13
-1 Month	10	1	1	6	2
1-11 Months	53	10	6	30	7
1 Year	10	1	1	7	1
2 Years or More	8	1	–	4	3
15-17 Years of Age	158	26	17	74	41
-1 Month	18	1	2	10	5
1-11 Months	88	15	12	42	19
1 Year	31	3	2	16	10
2 Years or More	21	7	1	6	7

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A study released in 1962 indicated a minimum need for 500 residential beds for children—a number far in excess of the then available resources. Privately operated facilities, such as Linwood, Child Study Center and Christ Child Institute, have a current capacity of 45. The Department, in addition to its Institute For Children whcih now has 85 patients (most are less than 12 years of age), now has separate units for adolescents with a combined capacity of 66 at the Crownsville and Spring Grove hospitals. The former has also established a day care program for a small number of disturbed children from one county (Anne Arundel). However, because of this shortage the majority of adolescents continue to be treated on the same wards with adult patients—a policy which is not believed to be conducive to the recovery of either group. Efforts to remedy this chronic deficiency must involve additional construction and staffing, both in state hospitals and in other facilities, as well as the close coordination of services with schools and all other present and proposed community resources.

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COMMISSIONER

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Learn To Do Your Part In The Prevention Of Disease

Accidental Poisonings in Baltimore City

In the first six months of this year, a total of 1,870 cases of accidental poisoning have been reported to the Baltimore City Health Department. At the present rate of these accidents, 1967's total reported accidental poisonings could reach the 4,000 mark.

This information is from a compilation of reported accidental poisoning cases in the city just released by Mr. Jacque G. Ayd, Director of the City Health Department's Bureau of Food Control. The reports are collected from 20 sources that treat accidental poisoning cases in the city, including 14 hospital emergency rooms, 3 comprehensive pediatric care centers and 3 pediatric clinics.

A breakdown of causative agents shows internal medicines leading the list with 1,235 cases and aspirin the most often misused medicine with 545 cases. Household chemicals were responsible for 230 cases.

By far the age group most often poisoned was from birth to 5 years of age with 1,205 cases, indicating that one important key to the reduction of poisoning accidents lies in more strict parental control of the activities of the preschooler.

It is suggested that physicians should urge parents to use extreme care in the handling and storage of all household poisons especially internal medicines while children are too young to know the danger of overdoses and misuse. A safe practice is to keep such products under lock and key when not in use at least until the child is of school age.

This statistical report is made possible through a new poison control ledger system instituted through the joint efforts of the Baltimore City Health Department, the Maryland Poison Information Center, and the hospitals of the city. Its use has also provided the Bureau of Public Health Nursing with repeater cases for accident prevention follow-up.

New Coordinator for VD

Mr. John Supinski of the US Public Health Service has been assigned as Coordinator of VD Projects in the Baltimore City Health Department.

Under the supervision of James E. Peterman MD, Director of the Bureau of Communicable Diseases, Mr. Supinski will administer case-finding and information and education projects for the Division of Venereal Diseases. In this post he has replaced Mr. Lawrence E. Posey who has been assigned to Regional Office III of the National Communicable Disease Center, Charlottesville, Virginia.

Robert E. Farber, MD
Commissioner of Health

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timed to work while your patient does

A study being conducted by the Department of Otolaryngology, Greater Baltimore Medical Center is stockpiling evidence that points to the fast action and prolonged relief effected by Triaminic in the treatment of nasal congestion.

Begun in March 1966, the study to date has encompassed 85 patients with common nasal disorders—and measured their response to recommended doses of Triaminic tablets.

Timed to release its oral nasal decongestant and two antihistamines within 8 hours, Triaminic was found to effect partial or complete relief in better than 82% of the subjects treated. Clearing nasal obstruction. Reducing turbinate swelling. Making breathing easier.

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Each timed-release tablet contains:

Phenylpropanolamine hydrochloride .....50mg. Pyrilamine maleate.....25mg. Pheniramine maleate.....25mg.

Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets.

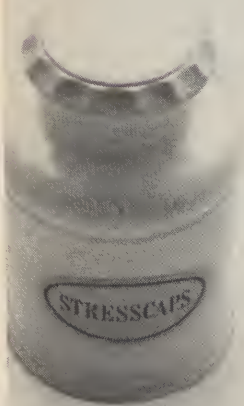
Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

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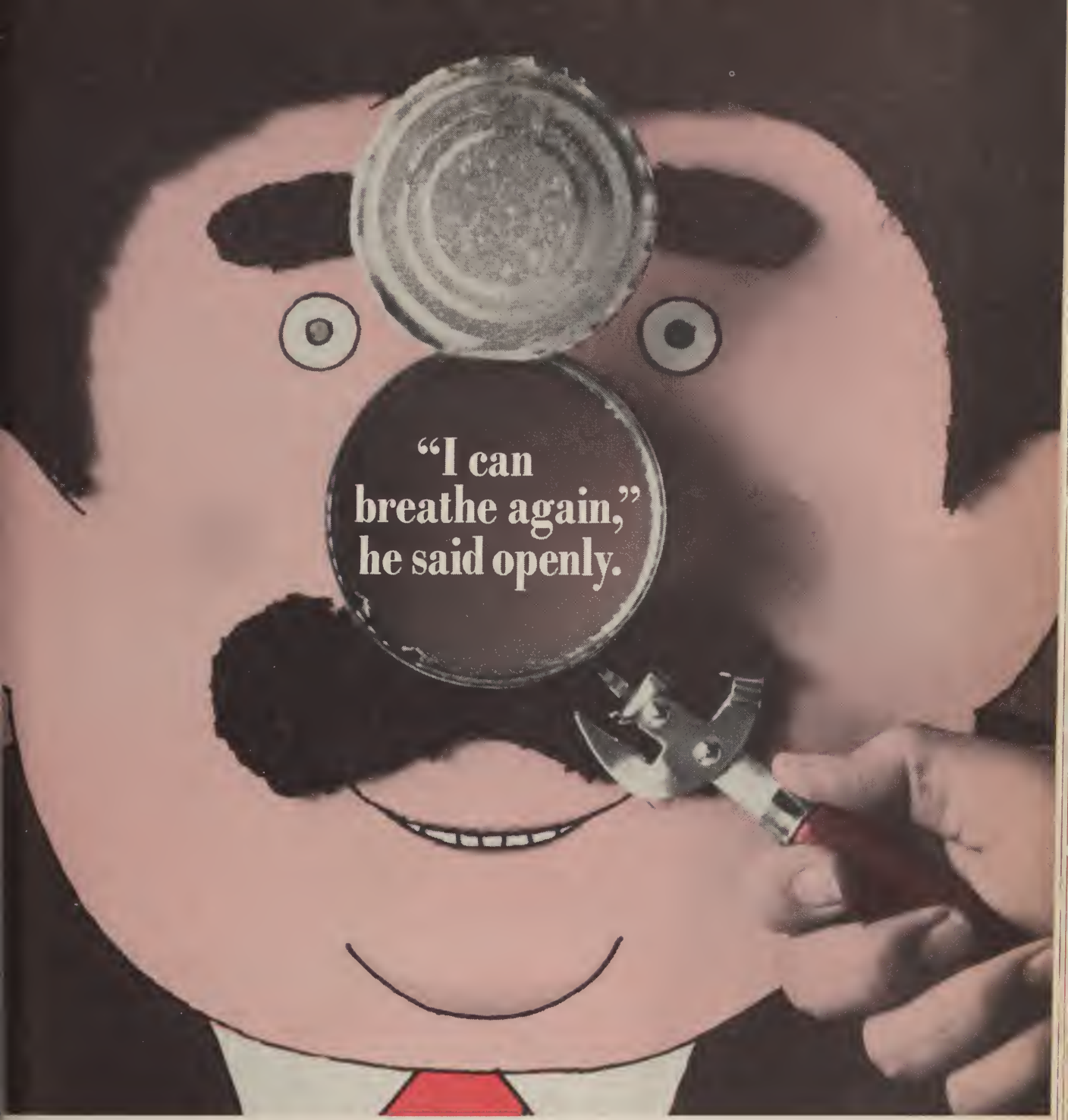
Each capsule contains:	
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Vitamin B_2 (Riboflavin)	10 mg
Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Vitamin C (Ascorbic Acid)	300 mg
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Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

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Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy. **Precautions:** Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. **Side Effects:** Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. **Dosage:** 1 Extentab morning and evening. **Supplied:** Bottles of 100 and 500.

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helps keep calories at arm's length

Preludin is indicated only as an anorectic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension, or pregnancy. For use in pregnancy, see Warning.

Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets® prolonged-action tablet a day, taken by midmorning.
Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.



Warning: Do not use during first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.
Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations, or delusions. Do not exceed recommended dosage.
Side Effects: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache. (B)R46-560-A

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controls diarrhea

In six published studies[1-6] detailed results are given on the use of Lomotil in 111 patients with chronic ulcerative colitis. They show that Lomotil gave satisfactory to "excellent" control of diarrhea in more than two-thirds of these patients. As the disorder advances and destroys bowel musculature, the motility-lowering action of Lomotil, understandably, has less effect.

The successful use of Lomotil in a disorder as exceedingly difficult to treat as moderate ulcerative colitis emphasizes again its unsurpassed antidiarrheal effectiveness in these more common conditions:

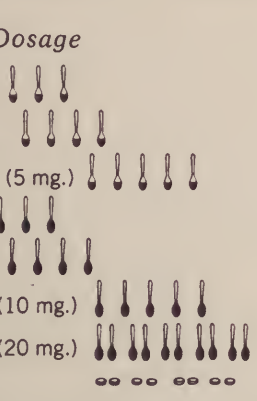
- **Gastroenteritis**
- **Acute infections**
- **Spastic colon**
- **Drug induced diarrhea**
- **Functional hypermotility**

For correct therapeutic effect
Rx correct therapeutic dosage

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are:

Children: Total Daily Dosage

3-6 mo. . . ½ tsp.*t.i.d. (3 mg.)
6-12 mo. . ½ tsp. q.i.d. (4 mg.)
1-2 yr. . . . ½ tsp. 5 times daily (5 mg.)
2-5 yr. . . . 1 tsp. t.i.d. (6 mg.)
5-8 yr. . . . 1 tsp. q.i.d. (8 mg.)
8-12 yr. . . 1 tsp. 5 times daily (10 mg.)
Adults: 2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.



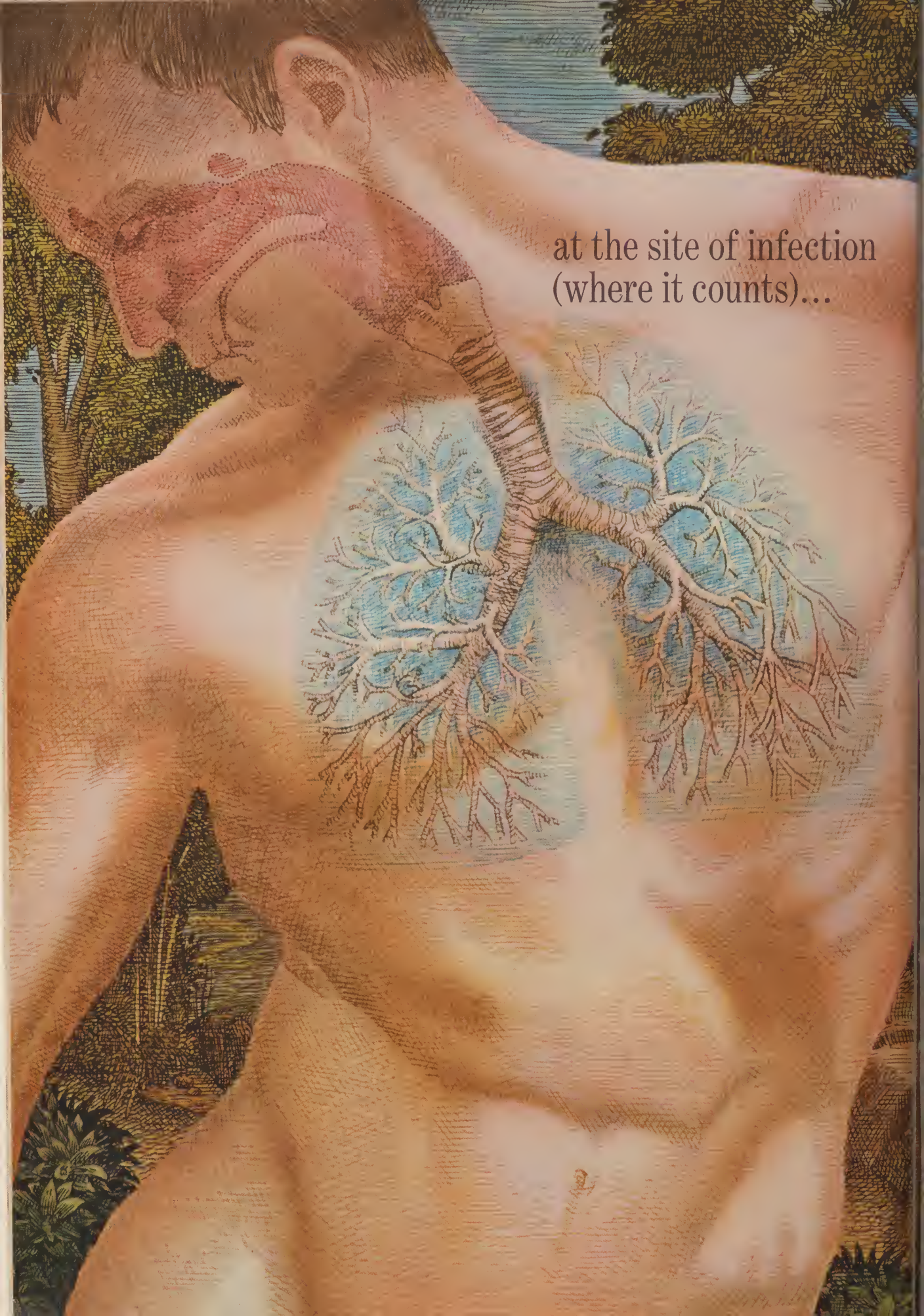
*Based on 4 cc. per teaspoonful.
Maintenance dosage may be as low as one-fourth the initial daily dosage.

Precautions: Lomotil is a federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and tachycardia. Lomotil should be used with caution in patients with impaired liver function or those taking addicting drugs or barbiturates.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of the extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

1. Barowsky, H., and Schwartz, S. A.: J.A.M.A. *180*:1058-1061 (June 23) 1962. 2. Cayer, D., and Sohmer, M. F.: N. Carolina Med. J. 22:600-604 (Dec.) 1961. 3. Hock, C. W.: J. Med. Ass. Georgia 50:485-488 (Oct.) 1961. 4. Van Derstappen, G., and Vandenbroucke, G.: Med. Klin. 56:962-964 (June 2) 1961. 5. Merlo, M., and Brown, C. H.: Amer. J. Gastroent. 34:625-630 (Dec.) 1960. 6. Weingarten, B.; Weiss, J., and Simon, M.: Amer. J. Gastroent. 35:628-633 (June) 1961.

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Ilosone® provides more antibacterial activity than any other oral erythromycin

Acid stable, better absorbed... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food[1-3]

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

Now available:
New! Ready-mixed Ilosone Liquid 125! (Contains erythromycin estolate equivalent to 125 mg. erythromycin base per 5-cc. teaspoonful.)

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(See next page for prescribing information.)

Ilosone®/ the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have also been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with pre-existing liver disease or dysfunction.

Adverse Reactions: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have developed in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly, usually within forty-eight hours, if the drug is readministered to sensitive patients. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appeared to be definitely related to use of the drug, laboratory findings were characterized by increased direct-reacting bilirubin, elevated alkaline phosphatase levels, negative or weakly positive cephalin flocculation and thymol turbidity tests, elevated serum glutamic oxalacetic transaminase levels, peripheral eosinophilia, and normal cholecystograms.

Individual idiosyncrasy seems evident since jaundice has not been reported in other patients taking prolonged courses of the medication. Patients with chronic infection have been given 1 to to 2 Gm. of the drug daily for periods of two to six months, and patients with rheumatic fever have taken prophylactic doses of 0.5 Gm. daily for two years without difficulty. In one group of 144 patients who received the drug daily for two years, no jaundice was noted. It was of interest that members of six of these patients' families, who were not taking the drug, had episodes of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels were determined in a group of fifty-four adults and children who took 250 mg. of Ilosone daily for an average of sixteen months as rheumatic fever prophylaxis. The results were compared with those of a similar group of forty-four patients who received penicillin. There were no cases of jaundice in either group. Elevation of SGPT and serum alkaline phosphatase levels during the course of treatment was observed in one patient treated with Ilosone and in two patients treated with penicillin. Seven other patients in the group receiving Ilosone and four others in the penicillin group showed elevations in one of the tests at some time during administration of the drugs.

Very satisfactory therapeutic results, without toxicity, were reported in 102 pediatric patients who received short-term (ten-day) courses of Ilosone in the treatment of streptococcus infections. Results of liver function tests in these patients were comparable to those in a similar control group who had received penicillin.

Gastro-intestinal disturbances not associated with hepatic effects are observed in a small proportion of individuals as a result of a local stimulating effect of the medication on the alimentary tract; however, the normal intestinal gram-negative bacterial flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with the use of erythromycin, there have been occasional reports of urticaria, skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orally.

Ilosone Pulvules®, Ilosone Liquid 125, Ilosone, 125, for Oral Suspension, Ilosone Drops, Ilosone Chewable Tablets.

For infants and for children under twenty-five pounds of body weight, the usual dosage is 5 mg. per pound every six hours; for children twenty-five to fifty pounds, 125 mg. every six hours. (Tablets Ilosone Chewable should be chewed or crushed and swallowed with water.)

For adults and for children over fifty pounds, the usual dosage of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythromycin therapy should be considered.

In the treatment of syphilis, the recommended total dosage is 20 to 30 Gm. given in divided doses for a period of ten to fifteen days. Close follow-up of the patient is necessary since erythromycin drugs have not had adequate evaluation in all stages of syphilis. Examinations of spinal fluid are recommended as part of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four days are recommended. In the treatment of gonorrhea, patients with a suspected lesion of syphilis should have a dark-field examination before receiving antibiotics, and monthly serologic tests should be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and 250 mg. (equivalent to base), in bottles of 24 and 100.

Ilosone Liquid 125, Oral Suspension, U.S.P., 125 mg. (equivalent to base) per 5-cc. teaspoonful, in 60-cc. and pint-size packages.

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equivalent to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size packages.

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 10-cc.-size packages, with dropper calibrated at 25 and 50 mg.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to base), in bottles of 50. [032767]

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:69, 1964. 2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:398, 1962. 3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 1960.

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.

Lilly

700970

DEPARTMENT OF HEALTH
STATE OF MARYLAND
William J. Peeples, MD, MPH, *Commissioner*

Highlights

FREE POLIO VACCINE FOR PRESCHOOL CHILDREN

Free trivalent oral polio vaccine (Sabin) is available through local health departments for administration to preschool children. Like the measles vaccine, the material is furnished to the State without cost, through the Federal Immunization Act. Physicians must certify that the vaccine is used for children under school age.

RUBELLA TEST PART OF PREGNANCY BLOOD SEROLOGY

Rubella, a reportable disease but one that often escapes detection, can cause serious damage to a fetus in its first trimester of development, and to a lesser degree in the second trimester. Physicians who suspect their pregnant patients may have, or have recently been exposed to, rubella may submit paired sera of blood samples (taken 14 to 21 days apart) to the Central Laboratory at 16 East 23rd Street, Baltimore 21218. A rise in antibody titre during the interim period indicates active infection. The first specimen should be drawn preferably within two or three days after symptoms appear or exposure to rubella occurs. Instructions for handling and mailing tubes may be obtained from local health departments. Complete details will be published in a forthcoming issue of the Journal.

RUBELLA WARNING GIVEN

John A. Grant, MD, Chief of the School Health Section of the Division of Maternal and Child Health, expects to visit the county medical societies this fall showing slides of rubella damaged children.

Chief concern is for that group born between Jan. 1, 1964, and March 31, 1965, whose mothers may have been exposed to rubella in the early months of pregnancy, during the epidemic of 1963-64. Preliminary studies suggest that possibly as many as 6000 children throughout the state may have suffered some birth handicap.

Clinical evidence of rubella damage most commonly is exhibited in failure to thrive or by the presence of one or more typical congenital anomalies such as heart defects, defects in vision or hearing, defects in other internal organs, and mental retardation. Positive laboratory findings will confirm the diagnosis.

MEDICAL STUDENTS COMPLETE SUMMER PROJECTS

Twenty medical students from the University of Maryland, Johns Hopkins, Yale University and Howard University medical schools, presented summaries of their summer projects in public health at the 15th Annual Public Health Seminar. The purpose of the student program is to assist future physicians to participate effectively in community health programs and to encourage cooperative efforts in preventive medical programs between private practitioners and local health personnel. Four dental students from the University of Maryland Dental School also participated in the summer program.

(*Continued on page* 149)

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BALTIMORE COUNTY

About 150 members of the Baltimore County Medical Association and their wives enjoyed the Annual Crab Feast of the Association held at Duffy's Restaurant on August 16, 1967. The Annual Crab Feast is a highlight in the year of the Association and the members are guests of the Association.

* * * * *

The membership approved a proposal that an appropriately engraved plaque be presented to each Past President of the Association. These placques will be presented at our Annual Meeting in December, which will be held at the Tail of the Fox.

* * * * *

The membership also approved a motion that five dollars per paid up member be presented to the Woman's Auxiliary for their projects.

The October meeting of the Association will be held at the Sparrows Point Country Club, the November meeting at the Greater Baltimore Medical Center with a seminar entitled "Common Eye Problems as seen by all Physicians," and the December meeting, with election of officers, will be held at the Tail of the Fox.

Dorothy E. Holman
Executive Secretary



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FILM EXPOSES HEALTH FRAUDS

Secret cures, "persecution by the medical profession," and other gambits of quackery are exposed in a 28-minute film, "The Health Fraud Racket," available from the Health Department film library. It is suitable for general audiences from junior high through adult level.

EMERGENCY HEALTH SERVICES SUBJECT OF SEMINAR

The respective roles of dentists, nurses, pharmacists and veterinarians during a national emergency were recently discussed and defined at a Professions Training Seminar sponsored by the Health Department, the Maryland Nurses' Association, the Maryland League for Nursing, the Maryland Dental Association, and the Maryland State Pharmaceutical Association.

STATE-WIDE X-RAY MACHINE TESTING IN PROGRESS

Antiquated or faulty radiographic equipment presents emission hazards both to the operator and the patient. The Division of Radiological Health has established an inspection schedule which will permit routine state-wide testing of X-ray equipment at approximate two-year intervals. However, anyone in doubt about the safety of his equipment may call for an inspection at any time. Improper conditions may often be corrected "on the spot," according to Robert E. Corcoran, Acting Division Chief.

Technicians should be reminded to stand well behind the protective barrier when making exposures. When using dental, mobile, portable and other equipment without a barrier, the operator must stand out of the useful beam, and as far from the patient as possible. This may be accomplished by use of an electrical supply cord sufficiently long to permit the operator to step out of the room during the exposure. Those using conventional fluoroscopic equipment should "dark adapt" in a darkened room or with red goggles for a *minimum* of 10 minutes prior to the fluoroscopic examination to permit use of a beam of lower intensity than would otherwise be required, and assuring a minimum exposure dose for floruoscopist and patient.

SANITATION CONTROL PROGRAM HIGHLY RATED

The Maryland Shellfish Sanitation control program, a joint responsibility of the Health Department's Division of Food and Milk and the Department of Chesapeake Bay Affairs, has received an overall rating of 96.2 points out of a possible 100 in an evaluation made by the United States Public Health Service. Further efforts will be made to seek out sources of pollution and correct conditions before closing of waters to shellfishing becomes necessary, to study the effects of time and temperature on harvested shellfish, to ensure code dating by packers, and to require certification by the State of all shellfish boats and handlers.

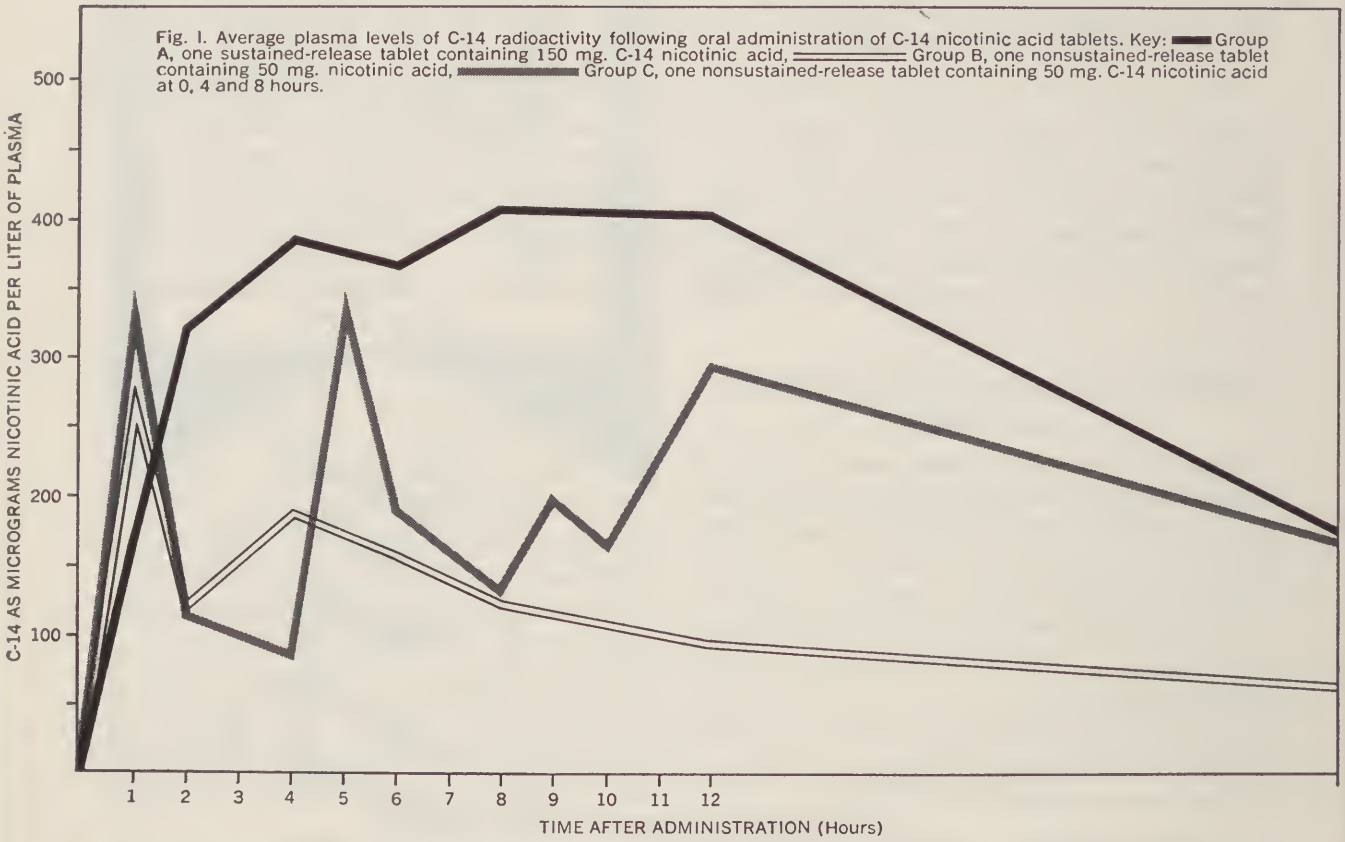
SANITARY TECHNOLOGY COURSES ESTABLISHED

Maryland Senate Bill 136, providing for the training and certification of water and wastewater treatment plant operators, has been implemented with the establishment of courses in elementary sanitary technology at four junior colleges—Hagerstown Junior College, Community College of Baltimore, the Charles County Junior College, and Chesapeake College. Successful completion of the course will enable registrants to qualify more easily for certification by a nine-man board appointed by the Governor. The curriculum was designed by the Division of Water and Sewerage, one of whose staff will serve as a member and secretary of the board.

4,000,000 POPULATION FORECAST BY 1971

If present trends continue, a total state population of four million is anticipated in another four years. As of July 1, 1966, the Division of Biostatistics estimated the total population at 3,615,750, about 515,000 more than the census of April 1, 1960. An increase of 123,000 over the estimated 1,965,960 persons now residing in the Baltimore metropolitan area (which includes the counties of Baltimore, Anne Arundel, Carroll, Harford and Howard) is anticipated by 1971. A gain of 230,000 for a total of 1,220,200 is projected for the two counties in the metropolitan Washington area (Montgomery and Prince George's).

Sustained circulatory, respirator
and cerebral stimulation for th





(fewer absent doses by absent-minded patients)

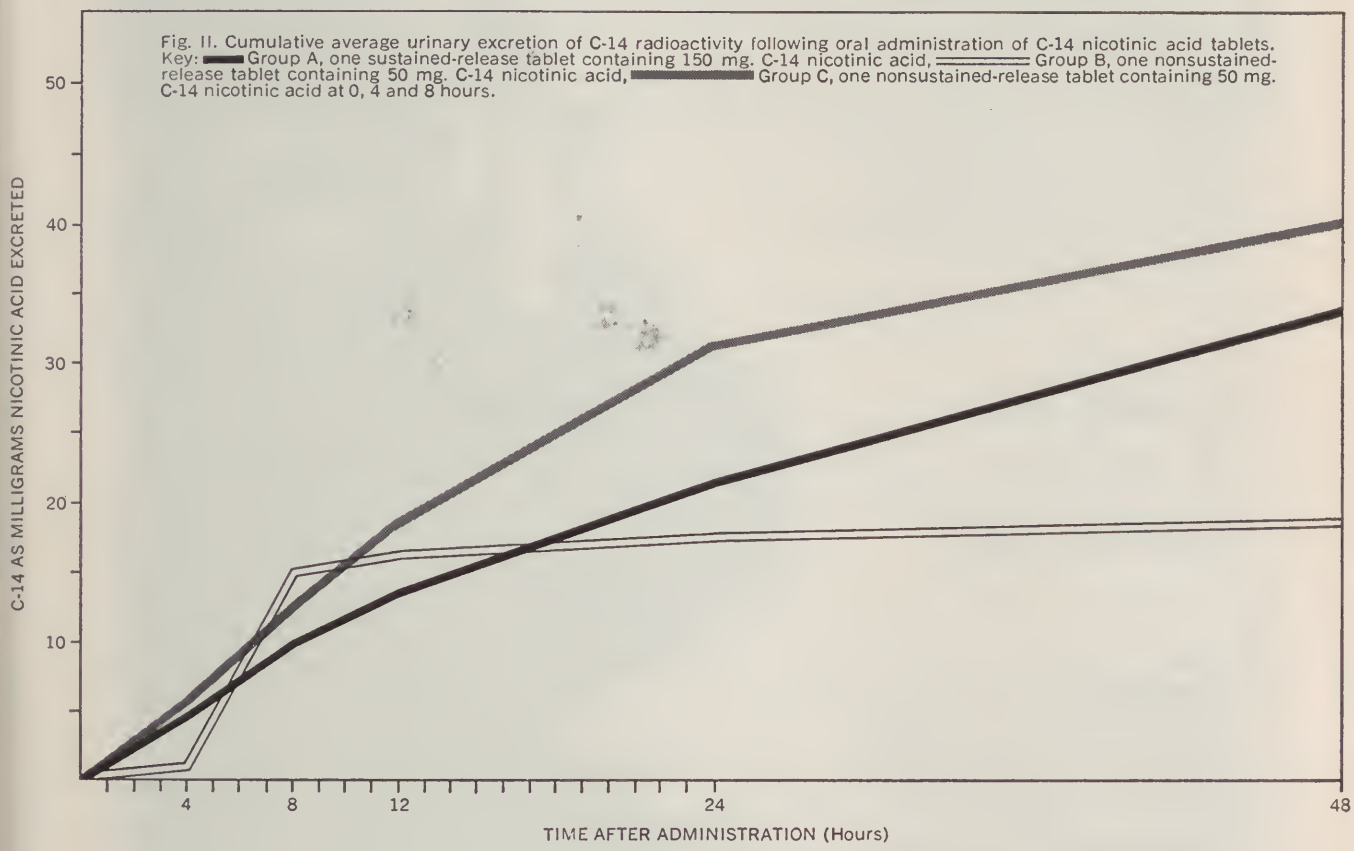
Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

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References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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Usage in Pregnancy: Use cautiously, especially in the first trimester. *Note:* The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.
Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible side effects of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported but no causal relationship has been established.



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the HEART PAGE
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THE PREGNANT CARDIAC PATIENT

CHRIS PAPADOPOULOS, MD
Chief of Cardiology
South Baltimore General Hospital

The internist and the cardiologist are not infrequently called upon to care for a pregnant cardiac patient. Knowledge of the particular problems that pregnancy creates for the heart and circulation is therefore essential. The incidence of heart disease in pregnant women varied in different studies between 1 and 7%. The most common heart disease in pregnancy is rheumatic which accounts for 80 to 90% of the cases. Congenital cardiovascular lesions occur in 1.5 to 5%; whereas hypertensive, syphilitic, and other types of heart disease are observed only occasionally.

To appreciate the effects of pregnancy upon pre-existing heart disease one must understand the circulatory adjustments which occur during normal pregnancy. (a) The oxygen consumption increases between 15 and 25%. (b) The cardiac output increases progressively up to the 28th or 30th week at which time it is usually 30 to 50% above normal. In the last 8 to 10 weeks of pregnancy there is a moderate fall in the cardiac output. The augmented cardiac output is due to acceleration of the pulse rate and increase of the output. (c) The work of the heart per beat an and per minute is increased by as much as the cardiac output. There is progressive acceleration of the circulatory speed from the 3rd to the 9th month of pregnancy. It diminishes moderately in the last weeks before term. (e). There is a progressive rise in blood and plasma volume beginning about the 13th week of pregnancy reaching a maximum around the 32nd week and diminishing thereafter. The total body water increases progressively and there is a tendency to retain sodium.

The circulatory adaptions in pregnancy are designed to satisfy increased metabolic demands of an enlarged uterus and its contents. Clinical observations suggest that structural changes occur in the walls of the maternal blood vessels. Spider angiomas may appear early in pregnancy. The majority of ruptures of aneurysms of the splenic artery occur during pregnancy and the growth of preexisting arteriovenous fistulas has been reported during pregnancy. Labor is relatively well tolerated as compared with the prolonged strain of pregnancy. Labor is associated with slight tachycardia, a moderate and transient elevation in arterial blood pressure and a corresponding increase in the work of the heart. Soon after labor there is an initial increase in blood volume due to emptying of the uterine sinuses. The highest incidence of heart failure coincides with the peak of the

circulatory load during pregnancy. Heart failure beginning during or immediately following delivery is infrequent.

Cardiac Manifestations in Pregnancy

A pregnant woman may present dyspnea, which may be due to increased respiratory effort to ventilate the deflated lungs of pregnancy or due to an abnormal subjective response to the hyperventilation and hypocapnia. She may present hypotension and syncope when she lies on her back because of the obstruction of the inferior vena cava and diminution of the venous return by the enlarged uterus. Edema of the legs develops in about 25% of the non-cardiac pregnant women especially during the last two months of pregnancy. That edema is not due to heart failure may be detected from the absence of venous engorgement of the cervical veins and from the normal venous pressure in the upper half of the body. The heart sounds may be accentuated and slight tachycardia is usually present. The patient with a normal heart may develop systolic murmurs. In the last few months of pregnancy one may hear a systolic bruit that originates in branches of the mammary artery and a continuous murmur that originates in the veins of the breast. Radiographic and electrocardiographic evidence of elevation and rotation of the normal heart due to pressure upward from the enlarging uterus accompanies normal pregnancy.

A careful history and physical examination is essential in diagnosing organic heart disease in pregnancy. Diastolic murmurs should be considered as evidence of heart disease unless proven otherwise. A machinery-like murmur will suggest the diagnosis of patent ductus arteriosus. Coarctation of the aorta may be suggested by the presence of hypertension and the absence of poor femoral artery pulsations. Fluoroscopic examination and an EKG may give the first clue of heart disease.

The physician has also to detect the presence of heart failure. Noticeable dyspnea, unexplained cough, or breathlessness awakening the patient from sleep should attract the attention toward this diagnosis. Relief of the dyspnea and the cough following extreme restriction of salt and one or two injections of Mercurial diuretics is a valuable diagnostic test to confirm the diagnosis of heart failure. In the presence of pulmonary congestion due to left-sided heart failure there is usually a reduction in vital capacity. Prolongation of the circulation time is also a valuable indication for the presence of failure. Of course, there is no difficulty if the patient has the complete clinical picture of heart failure.

Prognosis

With increasing knowledge and attention to the problems of the cardiac patient the mortality rate during pregnancy has been reduced. In recent reports the incidence of maternal deaths due to heart disease is 1% or less. The most common and serious complication of pregnancy in cardiac patients is congestive heart failure. Another is subacute bacterial endocarditis. Pregnancy and labor have been successful in many patients with congenital heart disease. The functional capacity of the heart and the presence or absence of cyanosis and heart failure are important determining factors in the outlook for pregnancy and labor in women with congenital cardiac lesions. There are many reports of pregnancies in patients with coarctation of the aorta and although the course may be uneventful, complications have been reported. Cases of coronary occlusion and acute myocardial infarction followed by pregnancy with successful termination have been reported. An increased fetal mortality has been noted with symptomatic heart disease in pregnancy.

Management

The main point in the treatment of the cardiac patient during her pregnancy is the prevention and control of heart failure. Cardiac patients should enter the hospital one to two weeks before the expected date of delivery for proper appraisal of the cardiac status, for planning of delivery procedure, and for the institution of treatment of incipient heart failure, if necessary. If heart failure has already developed, hospitalization may be necessary for an extended period of time before delivery. The changes in cardiac output and plasma volume during pregnancy can be limited by sodium restriction and the use of diuretics without jeopardizing fetal health. Disorders of the heart beat should be corrected. Quinidine or Procaine Amide may be administered without any additional risk because of pregnancy. Anemia should be avoided by the use of iron supplements

and if present, should be corrected. If there is any evidence of failure, the patient should be digitalized. Maternal heart disease is not an indication for premature delivery or Cesarean section. If, however, there is heart failure early in pregnancy (first three months) the patient should be aborted by dilatation and curettage after treatment to control the heart failure. The strain of labor should be minimized and the competent administration of anesthesia is very important. Most writers agree that non-operative management of the cardiac patient is preferred and that surgical intervention should be reserved for those patients with proven mitral stenosis who show progressive cardiac disability especially in the first two trimesters of pregnancy and which cannot be controlled medically. Surgical treatment for congenital heart disease is seldom necessary during pregnancy. Pregnancy in patients who have had previous cardiac surgical treatment must be evaluated on an individual basis.

In summary, pregnancy creates slightly more risk for the well compensated cardiac patient than the normal woman. The patient whose outlook is relatively unfavorable (patients who are in class 3 or 4 of the New York Heart Association Classification or those with a history of heart failure and atrial fibrillation) should be impressed with the increased maternal and especially fetal mortality. If pregnancy occurs, cardiac supervision and adherence to prophylactic and therapeutic regimen is necessary.

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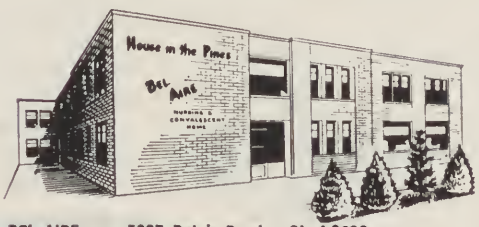
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MRS. HARRY L. BERMAN, Editor

"TEAM MATES"

Richard T. Binford, MD, was one of four children born to Quaker parents, residing in Greenbow, N. C. where his father, Raymond Binford, MD, was president of Guilford College. Dr. Binford grew up on the campus and attended Westtown Preparatory School for three years graduating from Guildford College. He then joined the University of North Carolina School of Library Science and after working in the field for four years he enrolled in Duke Medical School. Later he served his internship at Baltimore City Hospital where, he met his wife, Christine. He then acquired a Fellowship to The Johns Hopkins Hospital and worked in the Preventive Medicine Department.

He has practiced in Hagerstown since 1950 except for a three year period, two of which were spent in Atlanta, Ga in the VSPHS and one year in gastroenterology in Philadelphia at the University of Pennsylvania Hospital.

They are the parents of two girls, 18 and 16 and two boys, 14 and 11 years old. Dr. Binford is a stamp collector, and enjoys tennis, reading and music.

Mrs. Christine Binford attended public school in Wilkes-Barre, Penna. and graduated from Cedar Crest College in Allentown, Penna. where she majored in dietetics. Her internship was spent at the University of Pennsylvania Graduate Hospital. After working in Flushing, N. Y. she came to Baltimore City Hospital, and where, following a year of courtship, the Binfords were married. Christine still practices dietetics on a small scale and finds the time to serve as the Chairman of the Hospitality Committee of the Woman's Auxiliary to the Washington County Medical Society.

* * * * *



Dr. and Mrs. E. Gordon Grau

Formerly in private practice, E. Gordon Grau MD, is now the president of the Baltimore County Medical Association. While in private practice in the Loch Raven, Towson area, Dr. Grau was on the resident staff of Sheppard and Enoch Pratt Hospital. Dr. Grau is a graduate of Loyola College and the University of Maryland School of Medicine. In addition to the Baltimore County Medical Association he is a member of the Southern Medical Association, and an associate member of the Maryland and American Psychiatric Associations.

Mrs. Gordon Grau is a graduate of Notre Dame College of Maryland and is this year's Chairman on Legislation for the Woman's Auxiliary of Baltimore County Medical Society.



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Pediatrics

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WILSON L. GRUBB, MD, Chairman

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Scoliosis. Part II.

THE MANAGEMENT AND TREATMENT OF SCOLIOSIS

T. H. MORGAN, MD, FRCS (Eng.)
Division of Orthopaedic Surgery
University of Maryland Hospital

Non Progressive Scoliosis

Postural scoliosis is treated by physiotherapy, particular attention being given to posterior spinal exercises. It is usually more satisfactory for the child to be supervised in a physiotherapy department until the muscle tone is adequate to maintain correct posture.

Secondary scoliosis is treated by correcting the cause where possible—minor degrees of inequality in the leg length should be compensated for by shoe raises. In gross discrepancies of leg length, corrective surgery is normally justified.

Progressive Scoliosis

General Principles. In the treatment of progressive scoliosis, we are faced with differing problems depending on the age of the patient. With a patient seen for the first time at or after maturity, the problem is to decide if the symptomatology is sufficiently severe to necessitate treatment, and if so, what treatment should be given.

In the growing child, the problem is more complex. For besides treating deformity already present, our prime concern should be preventing the development of further deformity, especially in those patients in whom we suspect that the ultimate deformity will be of sufficient severity to cause disability. It is, therefore, important to recognize the curves with a bad prognosis, and those that are relatively benign.

As stated previously, the factors that determine the prognosis of a curve are:

1. Etiology
2. Curve pattern
3. Age at which deterioration starts
4. Rate of progression.

The etiology and curve pattern can, in the majority of patients, be identified from a single clinical and radiologicai examination, but the rate of deterioration and the age at which it starts, can only be determined by repeated examinations at regular intervals. Because of this, all patients with spinal curvature should be examined by an orthopaedic surgeon as soon as it is noticed, and the patient should be followed regularly at three monthly intervals until growth has ceased; the progress of the curve being assessed by clinical and radiological examination. A convenient method of estimating the progress of a curve is by graphic analysis. The measurement of the major curve, as determined radiologically is plotted against the age of the patient, and a progression graph constructed; this shows the rate of deterioration, and what is more important, alterations in

that rate are easily observed.

With experience in the interpretation of these graphs, it is, in many cases, possible to predict the ultimate major curve measurement, and thus, to some extent, the prognosis.

Methods of Treatment of Progressive Scoliosis

1. Physiotherapy
2. Appliances
3. Surgical procedures

Physiotherapy

Exercises have a definite place in the treatment of structural scoliosis, but it is important to appreciate their limitations, there being little evidence to suggest that they will halt or even diminish the rate of progression in a developing curve, and in the mature patient, though general posture may be improved, permanent correction of the curve cannot be effected. Breathing exercises directed towards increasing the vital capacity should be given, especially in those patients with significant thoracic deformity.

In later life when pain due to degenerative arthritis is present, other forms of physiotherapy, eg ultra sound and short-wave diathermy may be of benefit.

Appliances

Numerous types of jackets have been devised to effect the mechanical prevention or correction of the curvature. In the majority of these, the principle is to apply pressure to the prominent ribs on the convex side of the curve. On theoretical grounds, it would seem unlikely that much correction of the spine can be obtained by pressure on the malleable ribs of a growing child even if the skin would tolerate much pressure—furthermore it is of the greatest importance to maintain rib motility. For these reasons, the use of this type of brace should be discouraged.

Braces which aim at distraction of the spine, eg the Milwaukee Brace, are found to be more satisfactory.

Moulded leather jackets which maintain rather than correct are of value in unstable paralytic curves, and in selected severe cases of all etiologies in later life, when pain is the predominant symptom.

Surgical Procedures

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posterior spine fusion appears to be the most valuable operation, and in the majority of patients the mechanical corrections of the curvature is desirable prior to fusion, and this best effected by the Turnbuckle or Risser Jacket.

By this technique, in certain selected cases, the curvature can be considerably improved, and much of that improvement maintained by spinal grafting.

During the past decade the results of spine fusion have been improved, and to some extent, the procedure simplified by the use of Harrington's Rods—though the basic underlying principles of a solid fusion in the corrected position still apply.

This form of treatment is, however, lengthy and tedious to the patient, and as a secondary, but nevertheless important, consideration, it is very costly. It is, therefore, important that it should be reserved for those patients in whom the symptomatology is sufficiently severe to necessitate treatment and in whom the expected improvement is sufficient to make it justifiable.

In patients in whom posterior spine fusion has been performed at an early age in an attempt to stop or limit the progression of a developing curve, the results have been, in the majority of cases, disappointing, as the curves, despite apparent adequate fusion, tend to progress while growth continues.

For this reason, surgery should be withheld until toward the end of the growth period, usually between the ages of 13 and 15 years, although amongst different patients there is considerable natural variation. Thus a progressing scoliosis in a growing child can be one of the most distressing conditions in orthopaedic surgery as one may be obliged to wait until the deformity has almost fully developed before intervening with surgery. Because of this, in recent years procedures such as spinal osteotomy, epiphysiodesis of vertebral bodies, and anterior spine fusion have been performed, but in many instances the results have been discouraging. At present time, there seems to be little alternative to correction and fusion which produces, gratifying results particularly with late onset idiopathic curve and unstable curves of paralytic origin, but it will be appreviated that the selection of suitable cases requires considerable care, and the management considerable skill; for this reason, this form of treatment should only be carried out at specialized orthopaedic clinics.

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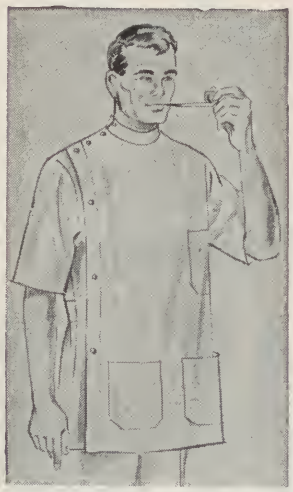
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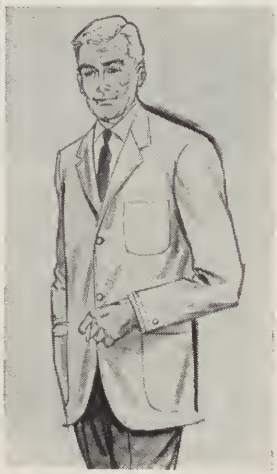
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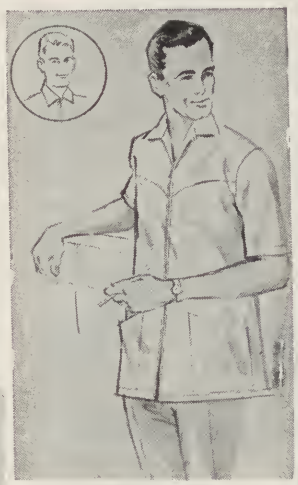
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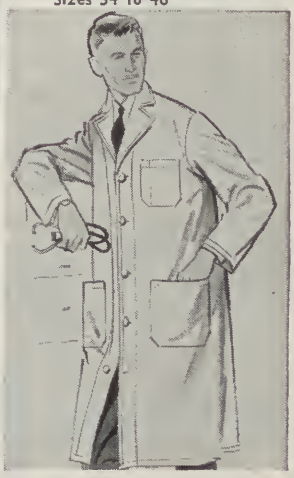
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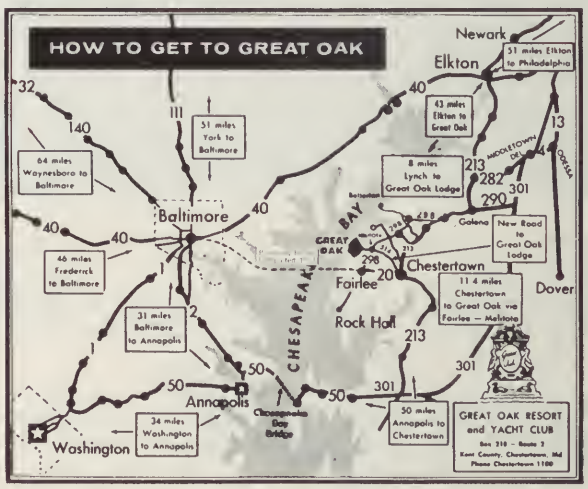
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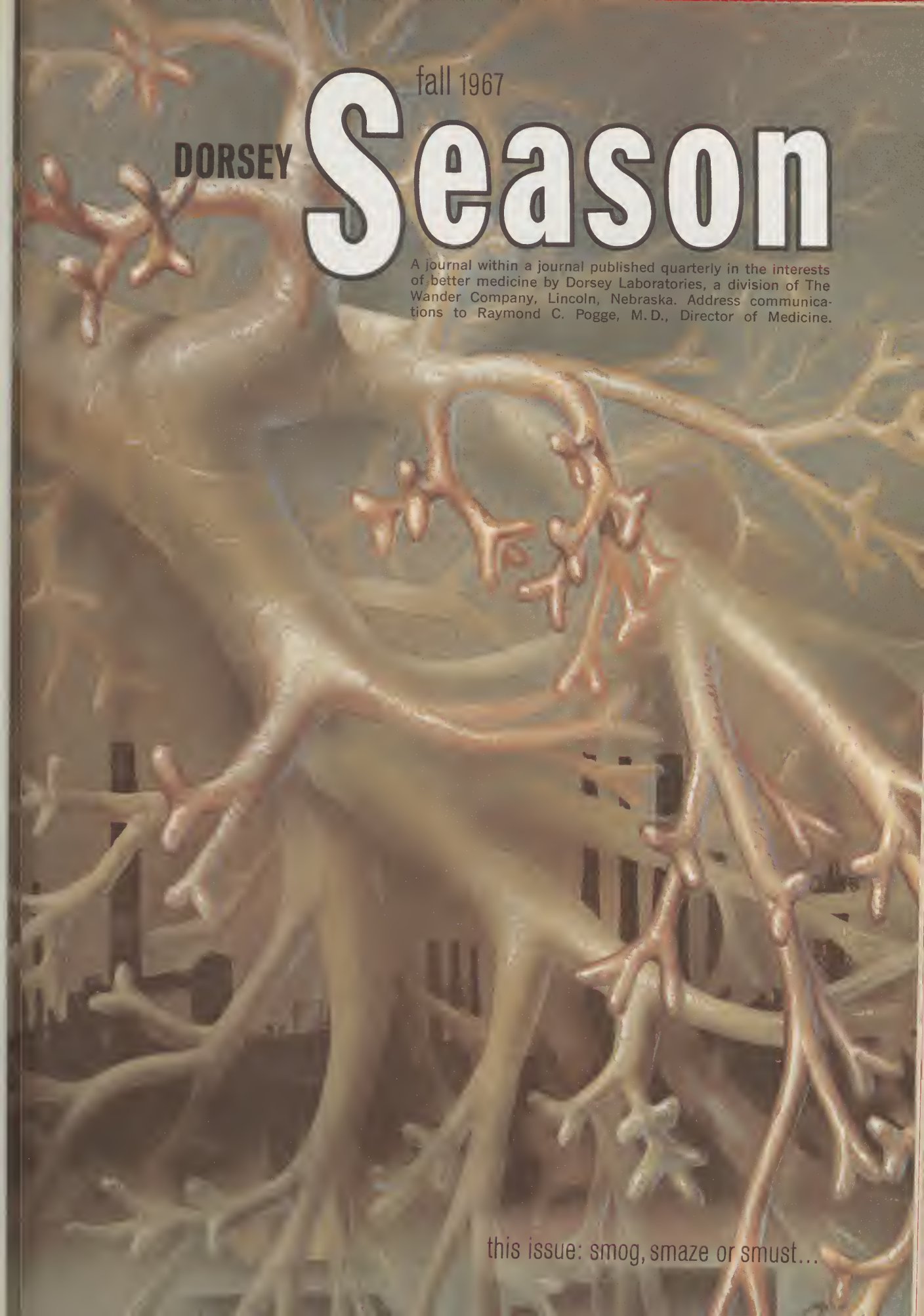
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this issue: smog, smaze or smust...

Smog, smaze or smust...effects of air pollution on upper respiratory tract

Nathan Flaxman, M.D., Diplomate, American Board of Internal Medicine, Chicago, Illinois

In Los Angeles it is *smog* (smoke and fog). In New York City *smaze* (smoke and haze). In El Paso *smust* (smoke and dust). The original factor was smoke plus such natural phenomena as fog, haze and dust, but air pollution has mushroomed from a smoke problem in our industrial cities into a major economic, esthetic and public health problem that affects practically every American locality and citizen.[1,2] Respiratory disease, of course, is by far the most costly effect of air pollution, for contaminated air can aggravate our illnesses, deplete our strength and shorten our life span.[1]

The greatest problem in dealing with solid wastes is that they are not quickly returned to dust. To aid the decomposing process, the great bulk of such waste is burned, polluting our air in the process.[3] Dr. Jack McKee of the California Institute of Technology[4] has calculated that in Los Angeles County, which has more than six million people, about three pounds of gaseous wastes per person per day (on a dry-weight basis) enter the atmosphere. This is twice as much as solid refuse disposal and six times as much as the contaminants in waste water. It is estimated that in New York City, 730 pounds of pollutants, a little over half the size of a compact two-door sedan of foreign make, is annually thrown into the air for each man, woman and child in the city.[5]

Air pollution is an evident factor, not only in the common cold and upper respiratory disease, but also in chronic bronchitis,[2] pulmonary emphysema,[6] bronchial asthma,[7] pneumonitis and lung cancer.[8] Its effect on the incidence of pulmonary tuberculosis is unproved,[9] although it is conceivable that the presence of various materials polluting the air might do this. A siege of smog in Denver, the "mile high city," in December 1965 was accompanied by respiratory infection that doubled normal absentee rates in schools, factories and city government.[10]

While air pollution is only one factor, it has become important in the causes of most of the afflictions of the respiratory tract. This has been shown not only by the Denver occurrence, but also by detailed study[2] of respiratory illness in a small group of 313 men



from October 1962 to May 1963 when there were 202 episodes involving the upper respiratory tract. The attack rate of illness was related in time to increased concentration of both smoke and sulphur dioxide in the atmosphere of the district in which the men lived.

Other factors often mentioned, include exposure to those who have colds, exposure to extreme changes of temperature, allergy and bacterial infection. However, when low individual resistance due to lack of rest, overwork, fatigue, improper or unbalanced diet, previous illness and emotional stress are included as causes, we enter the realm of somewhat obscure relationships. Much more emphasis can be placed on the role of polluted air.

The symptoms, signs and complications of involvement of the upper respiratory tract, especially the common cold, are the same regardless of the causative factor. Swelling of the lining of the nose, the scratchy dry throat, the discharge from the nose at first watery then thicker, discolored and more tenacious, the eyes tearing, and frequent sneezing are all part of the Number 1 human ailment. Concurrent or residual sinusitis when mucus is trapped there, middle ear involvement due to interference with drainage, laryngitis and bronchitis are complications of the common cold. The primary interference is with a most important function of the nose—the cleansing of foreign matter in the first line of "air defense" to prevent it from entering the breathing tract.

However, the diagnosis and subsequent decision on how to treat the patient so affected rests basically on the relief of symptoms that cause him the misery. The stuffed, runny nose, the clogged ears, and the harsh dry cough—all the symptoms that make common cold sufferers feel miserable and interfere with their sleep—can be alleviated with medications of the oral nasal decongestant/antihistamine combination type. The burning sensation in the throat, soreness of the chest and even chest pain can also be relieved by such medication. Rest in bed if there is fever (but confined to home at least), liberal fluids, uniformly warm surroundings and adequate humidity in the room, are all helpful adjuncts to the medication. Most common cold sufferers recover rapidly and are symptom-free in four to ten days.

Further treatment, altered by the fact that the affliction hangs on for more than the usual duration of the common cold, requires consideration of allergy, which is most frequently the prolonging factor. But air pollution itself may often be the culprit.

(Concluded on following page)

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At the Third National Conference on Air Pollution held recently, it was emphasized that this subject had received more attention in the past four years than in all previous history. Spicer,[11] an active participant at this conference, reiterated that it behooves the practicing physician to be aware of trends in respiratory disease and to accept a major role in community action relating to air pollution and respiratory health. By taking a positive stand physicians have been instrumental in the development of anti-pollution legislation. An outstanding example is Los Angeles where major steps have been taken by abolishing coal burning, and even banishing oil burning, seven months a year. Natural gas must be used instead and it must be used by industry when available. Backyard incinerators have been abolished in favor of landfill disposal, and building incineration ended except for a few expensive smokeless furnaces.[10] Concerted action can be taken against particular industrial nuisances. One company that disregarded complaints discovered its error when thousands of its credit cards were returned by irate customers who decided to patronize competing companies.[12]

Summary. Respiratory disease is the most important and most costly effect of air pollution, whether termed smog, smaze, or smust. Air pollution is an economic, esthetic and public health problem that affects practically every American locality and citizen. New sources of air pollution are invisible and odorless, but the harmful gases and liquid droplets are there. Triggered by sunlight, some of these undergo mid-air chemical changes and the results are even more irritating to the upper respiratory tract. The symptoms, signs and complications, especially of the upper respiratory tract, can be readily aborted by modern medication but may be unduly prolonged by polluted air. In steps taken to prevent this, the practicing physician can take a major role.

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REHABILITATION Notes

REHABILITATION SECTION
BALTIMORE CITY MEDICAL SOCIETY,

DOUGLAS G. CARROLL M.D.
EDITOR

Hand Function in Parkinson's Disease

DOUGLAS CARROLL, MD
Chief, Physical Medicine and Rehabilitation
Baltimore City Hospitals

All changes in function develop slowly in Parkinson's Disease; the changes in hand function may be among the first. Very early, the fingers may become flexed at the metacarpo-phalangeal joint. This position tends to be assumed whenever the patient is at rest. Somewhat later, trembling of the hand or arm may start, proceded or accompanied by easy fatigue. The awkwardness with fine movements, such as typewriting, piano playing and manipulating small buttons is secondary to a combination of weakness, lack of coordination, tremor and stiffness.

The stiffness and tremor gradually increase. Starting usually on one side, the other side is soon involved. The smaller muscles throughout the body seem to suffer more than the large muscles, notably in relative weakness, but also in coordination. Thus, writing deteriorates, becomes smaller in size (micrographia) and finally illegible. Gross changes in the posture of the fingers do not occur until the disease is far advanced.

Characteristic late changes of slight flexion of the distal interphalangeal joints, slight hyperextension of the proximal interphalangeal joint and flexion at the metacarpo-phalangeal joint ("intrinsic plus hand") are illustrated in Figure 1. Figure 2 shows a somewhat earlier pattern similar except for the absence of definite flexion at the metacarpo-phalangeal joint. Figures 3 and 4 show that the hand maintains its resting position when in active use. Hand changes are more common when rigidity is severe and tremor mild.

Charcot (1) drew attention to the resemblance between Parkinson's Disease and rheumatoid arthritis of the hand. Hughlings Jackson (2) noted that the interossei are principally involved and that the hand takes the position seen in tetany. Walsche (3) and Wilson (4) noted that rigidity is the cause of the deformities. Gortvai (5) described the improvement in hand posture following surgical lesions in the ventrolateral nucleus of the thalamus. He noted that paralysis of the ulnar nerve with procaine in patients with hand deformities of Parkinson's Disease results in the hand returning to a normal position. Stimulation of the ulnar nerve in a normal upper extremity at a point distal to the branches to the flexor carpi ulnaris and the flexor digitorum profundus results in characteristic flexion at the metacarpo-phalangeal joints and extension at the interphalangeal joints. There is good evidence, therefore, that the characteristic deformity seen in the hands in Parkinson's Disease is the result of muscular rigidity of the interosseous muscles.



Figure 1
Characteristic hand changes in late Parkinson's disease



Figure 2
Slightly earlier stages of hand change in Parkinson's disease



Figure 3
Method used to grip by patient with advanced changes of Parkinson's disease in the hand.

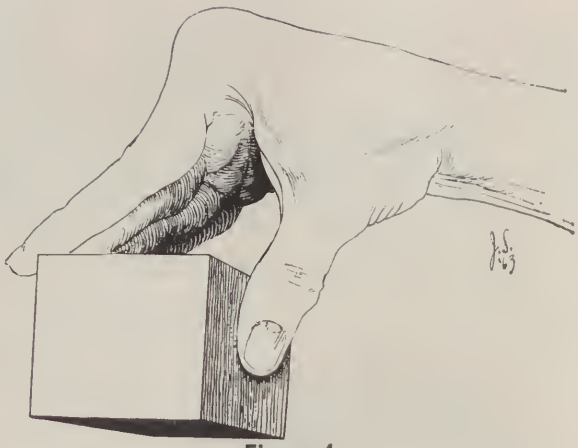


Figure 4
Method used to grasp by patient with advanced changes of Parkinson's disease in the hands.

Gortvai describes three stages of the hand deformity: first, an early stage with slight flexion at the metacarpo-phalangeal joint and extension at the interphalangeal joints. A second stage (Fig. 2) is characterized by increased extension at the proximal interphalangeal joint and beginning flexion at the distal interphalangeal joint. The third stage (Fig. 1, 3 and 4) is the same as stage 2 with marked flexion at the metacarpo-phalangeal joint.

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References: (1) Based on 23 clinical papers, 1512 cases. Bibliography on request. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: Antimicrobial Agents and Chemotherapy—1964, Ann Arbor, American Society for Microbiology, 1965, p. 722.

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Alcoholism
SECTION

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

About the Therapy of Alcoholics

ANDRE WEISS, MD
Staff Psychiatrist, Sheppard & Enoch Pratt Hospital
Instructor in Psychiatry, Johns Hopkins Hospital

The main purpose of this paper is to share the experiences encountered by me in treating, with psychotherapy, a small, but rather diverse group of inpatients. All of these patients represented serious drinking problems and were treated during the same period of time.

This study is written entirely in retrospect. During the actual stay of the patients in the hospital, when their treatment took place, the idea to write a paper about them had not been considered. This point is important to mention, because, apart from the obvious disadvantages this would present, I feel there is at least one important advantage as well. Because too often when studies or research are planned in advance, artefacts spoil the validity of a spontaneous and natural interaction between patients and therapist.

It is a well-known fact that the treatment of alcoholics in general practice, as well as in psychiatric practice, is a difficult and often frustrating experience. Few of them keep their appointments, few of them have the necessary motivation to undergo long-term psychotherapy. Zwerling[1] and his associates, reported that close to one-third of unselected volunteer alcoholics who applied to an outpatient clinic for treatment, failed to return after the first visit, and another one-third discontinued therapy before the first month was over.

I will commence with some of my experiences gained with alcoholic patients prior to becoming a psychiatrist, during my eight years of general practice in a small town. I will then describe how patients with drinking problems are treated at the Sheppard and Enoch Pratt Hospital, discussing the various policies and treatment approaches, and finally will go into some details about the patients in question and attempt to draw some conclusions.

As a general practitioner, I despised and was less than patient with the majority of alcoholics. It is interesting to note that very rarely could I call myself their family physician. Apparently, just as the alcoholic is ashamed to admit his disability to some of his relatives or friends, he is also reluctant to seek the help and advice of his family doctor, who is looked upon at times as a friend, other times as the boss, or even as the judge. These patients were apparently "shopping around" from doctor to doctor, exasperating everybody whom they consulted. Today I think rather, that the physicians, including myself, discouraged them to return for treatment with a negative, unfriendly, often critical attitude. I would like also to mention the attitude of the local general hospital, an attitude which is typical for the majority of hospitals in regard to alcoholism. I was several times criticized by the hospital authorities when I admitted somebody with severe symptoms due to acute or even chronic alcoholism. Sometimes I was obliged to, so to speak, smuggle them into the hospital, with an incomplete, or even false diagnosis, such as "Acute Gastritis," "Cardiac Decompensation," or I would only mention part of the diagnosis, such as "Cir-

Presented at the Sheppard and Enoch Pratt Hospital Scientific Day Program June 3, 1967.

rhosis of the Liver," or just "Severe Dehydration," leaving out the nasty word "Alcoholism."

I was always very impressed and sometimes surprised how rapidly these patients improved under intensive medical care when hospitalized. Intravenous fluids, vitamins, tranquilizers and some sedatives would, in a few days, put them back on their feet and they would return to the community, promising total abstinence. But these promises were rarely kept. I had invented a series of "gimmicks," all having one goal: to make them come back at regular intervals to my office, to "have an eye on them." These so-called gimmicks were weekly vitamin injections, weekly refills of prescriptions, but also periodic palpation of the liver and abdomen, as well as the check of blood pressure and weight. My psychotherapeutic approach was simple. All I would inquire was: "Did you drink this past week?" If the answer was no, I would praise them; if it was yes, I would get angry and threaten to not treat them any longer. I would also often tell them: "You are killing yourself!" I was acting as a judge and a policeman and was forcing them to lie to me. I have to admit that except for one single case in eight years, I never attempted to go deeper into the discussion of their background, family life or even the reason of their drinking. There was, however, one exception; a man I treated with intensive psychotherapy. In this case, I was his family physician and had attended his wife during her delivery of a child. He was an intelligent person, about 35 years of age. In place of the above mentioned gimmicks, at his request, I began to see him twice a week for a long talk. The therapy lasted for several months, during which time he came regularly to the sessions. Apparently, I also enjoyed the treatment, because why otherwise would I have spent so much time with him and not with the others? He stopped drinking and remained abstinent ever since. Here I would like to make my first point. In the case of an alcoholic, more than in any other psychiatric disorder, motivation for both patient and therapist is essential to achieve results. I will come back to this point in connection with another of the cases I propose to present.

At the Sheppard and Enoch Pratt Hospital the alcoholic patients are in general not treated differently from the other patients. Intensive individual psychotherapy associated with milieu therapy, and in some cases group therapy are our main tools. Most of us at *SEPH* do not consider alcoholism as a separate illness and put the emphasis on the treatment of the underlying affective disorders, personality disorder, or thinking disorder. I agree with the statement of Diethelm[2] that there is not sufficient evidence to support the claim that a special personality type predisposes to alcoholism and came to the conclusion that alcoholism is not a single entity or disease, but a symptom associated with several illnesses or syndromes.[3] I think that the variety of the pathology in the patients I had the opportunity to treat tends also to justify this opinion.

Sheppard-Pratt Hospital has some set rules and regulations concerning alcoholics. They are not admitted for very short stays for the sole purpose of sobering up. The patient with drinking problems is asked, during and after his hospitalization, to remain abstinent. No alcohol is permitted on the premises of the hospital. There is an alcohol committee composed of patients from various halls, who enforce the rules of abstinence. Membership on the committee is voluntary and often several of the members have or had drinking problems themselves. This committee would confront a patient who returned from town intoxicated and would see to it that no alcohol is consumed on the halls or grounds. The committee works in conjunction with the medical staff, which functions in an advisory capacity.

All patients are admitted to locked door halls and are given various permissions as they progress, this including the move to an open hall, ground or even town permission. If the alcoholic drinks during a trip into town, he is restricted to the hospital grounds for some time or even moved to a closed hall again, if this is found to be indicated. These restrictions are decided by the hall administrator, in consultation with the therapist. The milieu therapy consists of a variety of activities and assignments, as well as a new life experience on the hall. Occupational and work therapy, sports events, plays, literary activities, all contribute to give back to the patient the lost drive and will power and channel his interest into new areas. We are not encouraging, but at the same time, are not discouraging, either, the participation of such patients in AA meetings during their hospitalization. Such participation, however, is often encouraged after discharge. The use of

drugs is kept to a minimum.

Let us now discuss more in detail my patients in question. All of them, a total of seven, had been labeled as alcoholics by their referring physicians. It is not the purpose of this paper to try to give a definition of what the term "alcoholic" means. It seems to mean different things to different people,[4-6] and we will have to content ourselves with the fact that all seven patients were compulsive drinkers, whose drinking interferred with their family and professional lives, and became detrimental to their emotional and physical health. There were four females and three males who had started drinking from five to 25 years ago. All belonged to the middle-aged or late middle-aged group, between 42 and 49 years old. Four had graduated from college, including all three males. All of them were married, one of the females being a widow. Six of the seven had at least two or more children. All except one were voluntary admissions. The average stay was around four months; the shortest stay being one month, the longest nine months. They all had individual psychotherapy, 50 minute sessions, three times a week. Five participated in group therapy, in various groups with other therapists. The groups were not composed of alcoholics only. Most of these patients received ground permission after the first month of hospitalization. In spite of the fact that their diagnosis on the charts varied between passive-aggressive personality, reactive depression, obsessive-compulsive personality, schizoid personality and schizophrenia, it was striking that all patients were clinically depressed at the time of their admission. Most of them were not only emotionally, but also physically ill, this ranging from glaucoma, gastric ulcer, thyroid and liver ailment, hypertension, neuritis, petit mal epilepsy, fungus infections, etc. It was notable that their physical symptoms improved rapidly, in most cases without intensive medical treatment. After these statistics and generalities, let us discuss some of the patients more in detail.

A 48 year old widow (she looked at least 10 years older than her stated age), who had lost her husband several years before and who had been married twice before that, had no profession and no goals in life. Both of her parents were alcoholics and two out of three husbands were alcoholics as well. This case is presented to illustrate a so-called "hopeless situation." Her parents divorced when she was nine years old and she started to drink at the age of 18. She was first hospitalized because of her drinking at the age of 24 and several times after that for short periods of time and her long contact with psychiatrists did not seem to have made any difference in her condition. Her nervous system, vascular system and liver were pathologically altered by alcohol. From the beginning, she lacked motivation and after telling me, during several sessions, her life story, she signed herself out without attempting to use her hospitalization as a "new start." The prognosis in this case was and remains poor. Still, I was quite surprised when six months following her discharge she came back to talk to one of our social workers, stating that despite the fact that she had not stopped drinking, she was feeling better and needed much less alcohol to satisfy herself. She also stated that I had helped her a great deal and that she is thinking back to the sessions with nostalgia. And I began to think and look over my notes in an attempt to find out what in our sessions was helpful to this patient and why was I, apparently, at least partially, successful in treating her. I remembered one session in which she related in a rather matter-of-fact way an episode of her life when she was 10 years old, her parents had divorced sometime before and she lived with her mother and a maternal aunt, who would often go out at night, leaving her alone. Often she would lie alone at night in her bed, unable to sleep and cry out loud, "Daddy, Daddy," wishing that her father would be near her. It became apparent to me that all her life this woman had been looking for a father and could never find him again. I recalled how deeply moved I was during this session, because I felt very sorry for the child, not the mature woman in front of me. This feeling of the therapist had to be sensed by the patient, even if it was never openly talked about.

In the next case the same transference and counter-transference in a stronger and more therapeutic way were present. This case is very different in most aspects, even if there were some basic similarities with the previous case. The patient was a 49 year old male, a mining engineer, a high official in an industrial firm. He too, just as the previous patient, began drinking in his late teens, but he was able to finish his college studies and work himself up to a high position in his

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company. His drinking got out of hand for the past several years and he was hospitalized twice for short periods of time in general hospitals. He attempted suicide two years ago, slashing his throat and wrists superficially. He was chronically depressed and received a series of six shock treatments a few months prior to his admission to Sheppard Pratt Hospital, but his depression did not improve. It is interesting to note that several similarities between the patient's past life experience and my own were present. This gave me more incentive and motivation. The patient spent several years in Europe in boarding school, in the same country in which I studied. During World War II we both spent years in concentration camps. I knew well the small community he resided in, having worked there in the local community hospital for one year. To make his case even more interesting for me, a unique record about his childhood was available. His mother had written a book about the family's travels. Through this book, which I read, and through our sessions it became evident that he was a rather emotional and dependent child, who was forced into premature independence by rigid parents. He was raised in boarding schools or by grandparents, and soon learned that crying leads to nothing. He was forced to hide his emotions and withdrew into himself. At his mother's death in his early twenties, he did not cry. The death of his many friends in concentration camps in World War II left him apparently untouched on the surface. His war experiences were quite unusual and important. One day his captors transported several thousand American prisoners on a boat from one island to another. The patient was part of the transport. The boat was torpedoed and later sunk. All but four perished. He was in the water many hours and finally swam toward a distant lifeboat to be saved. This patient remained in our hospital voluntarily for six months and my main goal in his treatment was not to stop his drinking but to investigate the cause of his depression. Finally the answer came in a series of rather dramatic sessions. He began to recall that when the ship was struck by a torpedo, he was in the company of several good friends. As the boat did not sink at once, his friends decided to stick together and to try to help and save each other; but the patient suddenly panicked and jumped overboard, leaving his friends behind. There, in the cold water, he began to think of death and was not frightened. He was thinking that soon he would meet his mother again in Heaven. The thought of dying became more and more tempting. But suddenly, far away, he noticed a lifeboat, forgot about mother and friends and began to swim. Then he remembered his first night on the lifeboat together with three unknown survivors. He experienced auditory hallucinations and thought he recognized the voices of his friends calling for help. During the therapy session in which he related and relived this episode, the patient began to cry for the first time in treatment. He recognized his guilt feelings and how he had repressed and denied his sorrow until now. We are dealing in this case with a delayed depressive reaction, common in survivors of concentration camps.[7] The depression lifted gradually the following month and we were able to discharge him as much improved. Six months after the patient's discharge, he was functioning well and was abstinent.

The above-mentioned patient was motivated and wanted to get well. His drinking aggravated his depression. Karl Menninger[8] calls alcoholism suicide by inches, meaning that the alcoholic is slowly killing himself, using alcohol as a weapon. I sometimes wonder if this is so in all cases, and whether it is not the contrary that is true, namely, that alcohol can prevent suicide, acting as a tranquilizer or a short-term energizer, making the life of the depressed more bearable.

Discussing some of the reasons why patients were drinking, I would like to mention the school principal of a large school. He, too, remained at the hospital about six months as a voluntary patient, eagerly taking part in psychotherapy, group therapy and occupational therapy. This educator, for years, was looking to find a way to leave his profession, as his work became less and less rewarding. He became chronically dependent on alcohol and needed many drinks each night to be able to keep going. Then during one session the patient admitted that often in the past he was secretly hoping that he would become ill, not a serious illness, just ill enough to have to quit his job, and at this point, I commented: "But you have found your illness; it is alcohol. You were able to drink yourself out of your job."

This patient lacked sufficient motivation and desire to stop drinking. He resumed drinking soon after his discharge, but as his depression and his

outlook on life improved, he was able to drink less without so much of a guilt feeling as before. He went back to college and took up a new field.

Let me also mention the housewife who, due to conflicts regarding her sexual identity, had a psychotic episode with paranoid delusions and ideas of reference. Several years before her pscychotic decompensation, she began to drink large amounts of liquor each night. This case illustrates how alcohol can be the first symptom, a sort of precursor of psychosis. After treating her for close to six months, she developed, in the hospital a psychotic episode and had to be put on *Stelazine* (Tufluoperazine). This was the only patient in the group who was put on medication, and discharged on medication. She remained in the hospital for nine months and after her discharge made a marginal adjustment, but stopped drinking.

Another of my patients, a 42 year old male, was put, by his family physician, on *Antibuse* (Disulfrium) for over five years prior to his admission here. He stopped drinking, but became a drug addict, taking *Seconal* (Sodium secobarbital) or *Codeine* indiscriminately in large quantities. During his 20 years of alcoholism he exchanged his addiction back and forth several times, from alcohol to drugs and vice versa. This case illustrates the theory of Rado[9]—that it is not the toxic agent, but the impulse to use it which makes an addict of a given individual.

I think it is interesting to mention that despite the policy and orders of our hospital, banning alcohol and insisting upon complete abstinence, each of my patients who remained with us longer than six weeks became temporarily involved during their hospitalization, in some way, with alcohol. This involvement usually had a specific meaning or reason. I consider it as taking the place of messages and their significance became clear after having discussed it in therapy. It could also at times be seen as a way of interaction between a patient and his family or patient and his therapist. In most cases it expressed hostility, but sometimes it was a warning signal. As an example, I will present the case of the elderly housewife who remained five months in the hospital and who would go out with other patients for dinner. She would make it a point to pay for her friends' drinks, herself remaining abstinent during her stay at the hospital. After her discharge, she herself began to drink again. Or the patient, a middle-aged man, who, after four months' hospitalization and abstinence, would go home for the first time and find a bottle of liquor in the kitchen cabinet next to the carton of cigarettes, where no alcohol would be stored usually. This patient took one swallow from the bottle. What happened? It became evident that the patient wanted to punish his wife who left the bottle on purpose to test her husband's "improvement."

Now I arrive at last, and, I think, most important part of the alcoholic problem complex: the family, and especially the spouse, of the alcoholic. I firmly believe that if there is a "schizophrenogenic" mother,[10] so there is also an "alcohologenic" spouse. Such a spouse can be so exasperating, domineering and critical that there is no other way out for the patient than either to divorce or to drink. Often after a long interview or telephone conversation with some of the wives of my alcoholic patients, I, the therapist, have felt so desperate and depressed that I could have well used a drink. Some members of the families of alcoholics are extremely difficult to handle. All family sessions I attempted with them have been a failure and an untherapeutic experience. I would like to emphasize here how important it is for the spouses to have more contact with social service, especially in a place like Sheppard Pratt Hospital, where usually, during psychotherapy, the alcoholic symptom is somewhat left in the background. If possible and if indicated—and in most cases it is—the spouse should be recommended for individual or group therapy.

In conclusion, it is significant that all seven patients I have treated in psychotherapy have developed positive transference rather rapidly, which was helpful in treating them. The motivation of the patient, but also of the therapist, is of enormous importance. The results will often depend on the attitude of the therapist. Understanding and absence of criticism are the most valuable tools. When some of the patients asked me how they could find the strength to stop drinking, I had no answer to offer them, and I have no answer now. It is up to them to find an answer. I feel that we have to insist on total abstinence, but I also feel that these people can be helped even if the total goal cannot be attained—compromises are possible. Occupational and work therapy are of

great importance for hospitalized patients. Sometimes they can find new outlets and new interests which would take the place of their drinking. The new environment and the separation from a stressful situation at home or on the job were, by themselves, enough to help most people stop drinking during their hospitalization. Sometimes it is only by changing their home environment, their job situation and even their profession, that the total goal can be achieved. Sometimes they have to find a new purpose in life. Individual psychotherapy's goal is the awakening of insight, and also to make unhappy people somewhat happier. Only unhappy persons will become problem drinkers and what makes one happy is so individualistic and so diverse that no recipes can be used.

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BALTIMORE CITY MEDICAL SOCIETY

1211 Cathedral Street, Baltimore, Maryland 21201
Friday, Nov. 3, 1967, 8:30 pm
Medical Legislation and the Medical Profession
The Honorable Charles McC. Mathias, Jr.,
Congress of the United States
Question and Answer Period
Acceptable for 2 hours Category I Credit by the American Academy of General Practice

There will be a report of the Nominating Committee and nominations from the floor during the business meeting immediately following the scientific program. Nominations for four members of the Nominating Committee for 1968, and final action on amendments of the bylaws will also take place.

MARYLAND PSYCHIATRIC SOCIETY

Francis McLaughlin, MD, President
Eugene Brody, MD, Secretary
Thursday, Nov. 9, 1967, 7:00 pm
Dinner Meeting, Sheppard and Enoch Pratt Hospital
Panel on Hospitalized Adolescents. Robert W. Gibson, MD, Irving M. Ryckoff, MD, Joseph Noshpitz, MD

MARYLAND EAR, NOSE AND THROAT SOCIETY

Irving L. Ochs, MD, President
Samuel M. Lumpkin, MD, Secretary
Tuesday, Nov. 14, 1967
Cocktails 6:30 pm, Dinner 7:00 pm,
Meeting 8:00 pm
Sheraton-Belvedere Hotel, Jubilee Room
Combined Craniofacial Surgery as Treatment for Extensive Benign Tumors of the Nose, Sinuses and Nasopharynx. Lt. Col. Edmund A. Krekorian, MC, Chief of Otolaryngology Service, Department of Army, Walter Reed General Hospital, Walter Reed Army Medical Center.

MARYLAND PEDIATRIC SOCIETY

Matthew Debuskey, MD President
Anthony Perlman, MD, Secretary
Tuesday, Nov. 14, 1967, 8:30 pm
Business Meeting—To consider disbanding the Maryland Pediatric Society.

PATHOLOGY SECTION

Edward L. Sherrer, MD, Chairman
William J. Hicken, MD, Secretary
Monday, Nov. 20, 1967, 8:00 pm
Program to be announced.

MARYLAND DERMATOLOGICAL SOCIETY

Raymond C. Vail Robinson, MD, President
Herbert L. Kronthal, MD, Secretary
Monday, Nov. 27, 1967
Penn Hotel, Towson, Maryland, 6:30 pm
Endocrinology and Dermatology. John G. Wiswell, MD, Associate Professor, Department of Medicine, University Hospital.

ANESTHESIA STUDY COMMITTEE

Joint Anesthesia Study Committee of the Baltimore City Medical Society and the Baltimore City Health Department.
Tuesday, Nov. 28, 1967, 7:30 pm

MEDIC

FRIDAY POSTGRADUATE PROGRAMS

Nov. 3, 1967, 12:30 pm

EMOTIONAL DISTURBANCES IN THE AGED—Panel Discussion

Myron F. Eichler, M.D., Moderator
Maryland Psychiatric Society

Nov. 10, 1967, 12:30 pm

BETA ADRENERGIC BLOCKADE AGENTS

Bernard Tabatznik, MD
Sinai Hospital of Baltimore, Inc.

Nov. 17, 1967, 12:30 pm

POISONING AND POISON CONTROL

Gina M. Glick, MD
Elizabeth G. Brings, MD
Sacred Heart Hospital

Nov. 24, 1967, 1:00 pm

CARDIAC FAILURE IN INFANCY AND CHILDHOOD

Catherine A. Neill, MD
Frederick Memorial Hospital
Check Maryland State Medical Journal for listing of *MEDIC* locations.

COMING MEETINGS—DECEMBER, 1967

BALTIMORE CITY MEDICAL SOCIETY

Friday, Dec. 1, 1967, 7:30 pm

ANNUAL BUSINESS MEETING

Report of officers and committees. Election of Officers, Delegates, Alternate Delegates, Members of the Nominating Committee for 1968, and Presidential Address.

SOCIAL HOUR, 9:00 pm

The doctors are cordially invited by the Woman's Auxiliary to the Baltimore City Medical Society to join them for refreshments and entertainment following the meeting of the Society.

WOMAN'S AUXILIARY TO THE BALTIMORE CITY MEDICAL SOCIETY

Friday, Dec. 1, 1967

Business Meeting—8:00 pm

Joint Social Hour for Members and Husbands —9:00 pm

All meeting's will be held at 1211 Cathedral St. unless otherwise stated.

* * * * *

Medic Program

Participating hospitals:

Anne Arundel General, Annapolis
Baltimore City, Baltimore
Baltimore County General, Randallstown
Calvert County, Prince Frederick
Cambridge-Maryland, Cambridge
Carroll County General, Westminster
Church Home, Baltimore
Cumberland Memorial, Cumberland
Easton Memorial, Easton
Eugene Leland Memorial, Riverdale
Frederick Memorial, Frederick
Greater Baltimore Medical Center, Towson
Harford Memorial, Havre de Grace
The Johns Hopkins, Baltimore
Kent & Queen Anne's, Chestertown
Lutheran, Baltimore
Maryland General, Baltimore
Montgomery General, Olney
North Charles General, Baltimore
Peninsula General, Salisbury
Prince George's General, Cheverly
Provident, Baltimore
Sacred Heart, Cambridge
St. Josephs, Baltimore
St. Mary's, Leonardtown
Sinai, Baltimore
Union Hospital of Cecil County, Elkton
Union Memorial, Baltimore
University of Maryland, Baltimore
Washington County, Hagerstown

Other locations:

Medical and Chirurgical Faculty, Baltimore
State Office Building, Baltimore
Hospital Council of Maryland, Inc., Baltimore

MEDIC PROGRAM FOR OCTOBER AND NOVEMBER

OCTOBER 27—1:00 P.M.

Prognostic Assessment of the Cardiac Patient in Need of Surgery

J. O'Neal Humphries, MD, Assistant Professor of Medicine, The Johns Hopkins University School of Medicine

Sponsor: Frederick Memorial Hospital

NOVEMBER 3—12:30 P.M.

Emotional Disturbances in the Aged Panel Discussion

Moderator: Myron F. Eichler, MD, Research Assistant Professor, Department of Psychiatry, University of Maryland School of Medicine

Sponsor: Maryland Psychiatric Society

NOVEMBER 10—12:30 P.M.

Beta Adrenergic Blockade Agents

Bernard Tabatznik, MD, Chief Cardiologist, Sinai Hospital of Baltimore, Inc.

Sponsor: Sinai Hospital of Baltimore, Inc.

NOVEMBER 17—12:30 P.M.

Poisoning and Poison Control

Gina M. Glick, MD, Poison Control Officer, Sacred Heart Hospital
Elizabeth G. Brings, MD, Pediatrician, Cumberland

Sponsor: Sacred Heart Hospital

NOVEMBER 24—1:00 P.M.

Cardiac Failure in Infancy and Childhood

Catherine A. Neill, MD, Associate Professor of Pediatrics, The Johns Hopkins University School of Medicine

Sponsor: Frederick Memorial Hospital

For further information contact:
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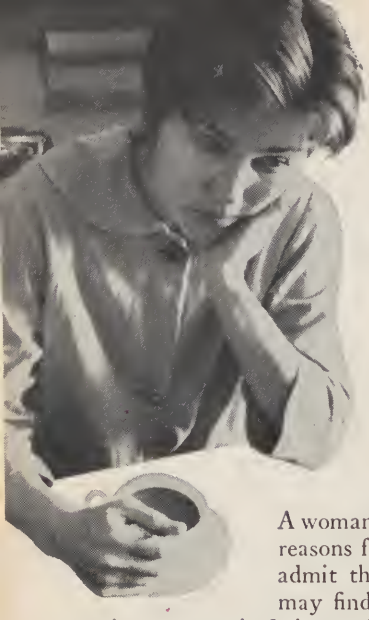
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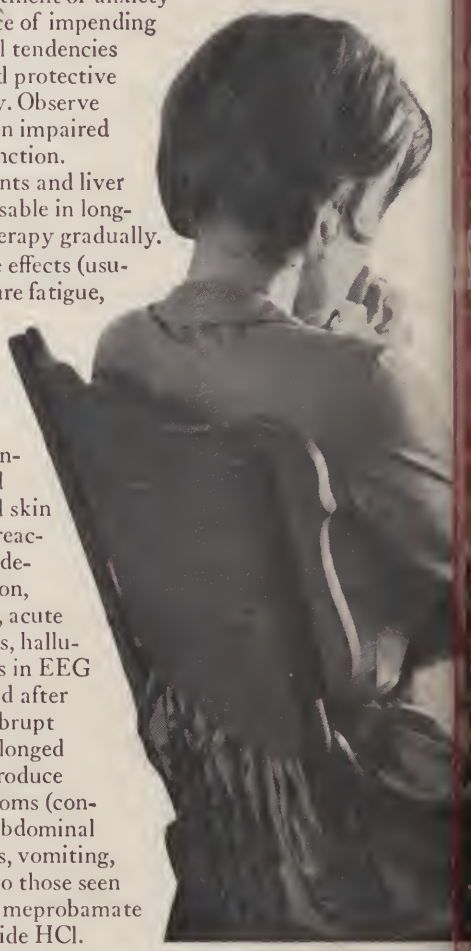


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Contraindications: Infants, patients with history of convulsive disorders, glaucoma or known hypersensitivity to drug.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

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Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances, acute hyperexcited states, hallucinations); changes in EEG patterns during and after drug treatment. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms (convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

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References:

(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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Maryland
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November, 1967

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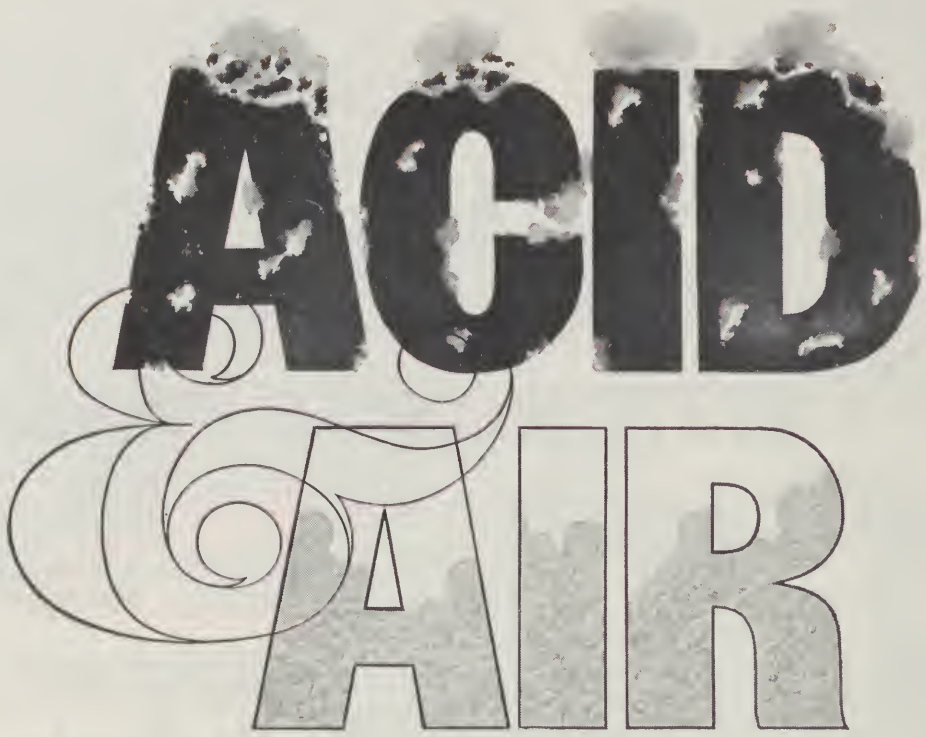
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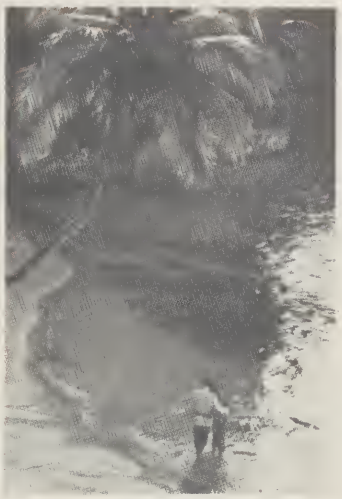
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Jamaica
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an island, a city...a way of life rich in legend and luxury



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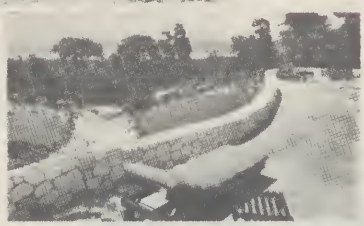
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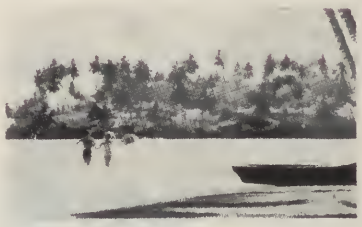
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November 26-29

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November 27-30

Medical Genetics—University of Michigan Medical Center, Ann Arbor, Michigan. Contact Edward C. Rosenow, Jr., MD, Executive Directar, 4200 Pine St., Philadelphia, Pa. 19104.

AMERICAN COLLEGE OF PHYSICIANS

December 2, 1967

Regional Meeting—Marylond and District of Calumbia, 8:30 a.m.-4:30 p.m. in the Auditorium of the Medical Services Library, University Hospital, Lombard and Greene Sts., Baltimore, Md.

AMERICAN COLLEGE OF PHYSICIANS

December 4-7

4th Annual Postgraduate Course—on Pulmonary Function in Health ond Disease—in Auditorium of Louisiono State University School of Medicine. Contact Alan B. Borne, Suite 407, 305 Baronne St., New Orleans, La. 70112.

LOUISIANA THORACIC SOCIETY

December 10

Board of Directors Meeting—Moryland Room, Holiday Inn Downtown, Boltimore, Md. 11:00 o.m. Contact G. Overton Himmelwright, MD, 133 Virginia Ave., Cumberlond, Md. 21502.

MARYLAND ACADEMY OF GENERAL PRACTICE

January 11-13, 1968

First International Canference an Prematurity—Pier 66, Fort Lauderdale, Florida. Contact Wesley J. Duiker, Secretary, Committee on Maternal and Child Care, American Medicol Association, 535 North Deorborn St., Chicoga, Ill. 60610.

AMA COMMITTEE ON MATERNAL AND CHILD CARE

January 19-20, 1968

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January 24, 1968

Meeting—Speaker, Alston Callahan, MD, on Surgicol Advances in Ophtholmology at Kennedy Warren Hotel, Washington, D. C. Contact Leonard L. Kagan, MD, 1106 Spring Street, Silver Spring, Md. 20910.

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APRIL 17, 18, 19, 1968

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A committee of the Medical Society will be the judges and the winner will be presented with a certificate, suitably inscribed with the title of the exhibit and the author's name. A prize of $200.00, donated by Mead Johnson Laboratories, will be presented to the winner during the convention.

All scientific exhibits accepted for showing at the 1968 Annual Meeting of the Faculty will be eligible for judging. Physicians interested in submitting exhibits should make application to the Chairman, Committee on Program and Arrangements, Medical and Chirurgical Faculty, 1211 Cathedral Street, Baltimore, Maryland 21201.

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April 17, 18, 19 Alcazar, Baltimore
April 21-28 Caribbean Cruise Convention

IN BALTIMORE

Wednesday, April 17— 8:00 A.M.—Business Meetings of Specialty Societies
9:30 A.M.—Meeting of the House of Delegates
12:30 P.M.—"Quiz the Experts" Luncheon
2:15 P.M. to 4:30 P.M.—Scientific Session
8:15 P.M.—Theater benefit for AMA-ERF

Thursday, April 18— 9:30 A.M.—Medical Grand Rounds followed by a lecture
2:15 P.M.—Surgical Grand Rounds followed by a lecture
6:15 P.M.—Annual Presidential Reception and Banquet

Friday, April 19— 9:30 A.M. to 12 Noon—Scientific Session
2:00 P.M.—Meeting of House of Delegates

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Sun., April 28—Arrive Baltimore in the afternoon about 2:00 P.M.

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August 28, 1967

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These are significant times for all American citizens and for American Medicine. This is a cordial and earnest invitation for you to join us in a re-evaluation of our resources, abilities and opportunities and then with courage and enthusiasm proceed to utilize and develop them.

This will involve us and you individually as participating citizens and faithful physicians, and collectively as more diligent and effective workers in our county medical societies, state associations, specialty groups and the American Medical Association. To this joint effort we invite your enthusiastic and wholehearted cooperation.

The greatest need is probably for more efficient, fruitful communication. We urge you to take a few minutes each month to read the President's Page in your county medical bulletin, state medical journal, and first issue each month of JAMA. We promise you a brief, worthwhile message every month, emphasizing and referring you to things that will interest you. An efficient review of each copy of The AMA News will keep you posted on general developments.

You will enjoy and profit from your membership in medical groups in direct proportion to your investment of time in them. We will anticipate seeing you regularly at our medical meetings.

The public relations of Medicine depends on how you and your office aides serve your patients, and how you perform as a citizen.

We will welcome your suggestions at all times, and we thank you sincerely for your cooperation.

Cordially,

Milford O. Rouse M.D.

Milford O. Rouse, M. D., President
American Medical Association

R. D. Bauer M.D.

Richard D. Bauer, M.D., President
Medical and Chirurgical Faculty of Maryland

Your MEDICAL FACULTY at Work

JOHN SARGEANT EXECUTIVE SECRETARY

The Faculty's House of Delegates in its Semiannual Session, Friday, September 8, 1967, took the following actions:

1. Adopted a minor amendment to the Medicolegal Code of Cooperation which brought the Faculty's action in line with that of the Bar Associations.

2. Adopted a Pharmacist/Physician Code of Cooperation.

3. Moved various Bylaw amendments.

4. Approved Emeritus Membership for various individuals on the request of their component society and recommendation of the Council.

5. Recommitted the proposed Commission on Medical Discipline for further study in consultation with the Board of Medical Examiners so as to reconcile differing views; and authorized a special meeting of the House of Delegates in sufficient time for preparation and introduction of legislation for the 1968 State Legislature.

6. Adopted the following motion:
"Resolved, That the House of Delegates reaffirm its policies adopted on September 18, 1959, and the policy adopted by the House of Delegates of the American Medical Association in December, 1959, disapproving the concept of closed panel paractice of medicine when the patient contributes financially to its support, as an abridgement of the patient's freedom of choice of physician."

7. Resolved that Resolution 1S/67 be postponed indefinitely.

The Council at its October 5 (Special) meeting took the following action:

1. Approved minutes of the Council and Executive Committee meetings.

2. Accepted the recommendations of the Med-Chi Insurance Trust in connection with a retirement program for Faculty members and their employees; and authorized officers to complete the necessary documents to place the program in effect.

3. Established Saturday, November 11, at 2:00 p.m. for the special meeting of the House of Delegates to consider the proposed Commission on Medical Discipline.

4. Authorized the chairman of the Professional Medical Relations Committee to deal with any necessary groups or organizations to implement the House of Delegates action dealing with payment of Usual, Customary and Reasonable fees under Workmen's Compensation cases.

The Executive Committee at its October 5 session:

1. Heard a report on the Mass Measles Immunization drive and learned that a total of $5,260.06 surplus has been placed in a special fund for use in future immunization drives. Heard that $11,-122.05 of the $15,000 appropriation from the educational fund for publicity and education in this drive, had been spent.

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600048

2. Discussed the question of financial support for the Woman's Auxiliary and requested the Treasurer to consider this when developing the 1968 budget.

3. Authorized a suitable financial amount to be sent to the Oakland Memorial hospital in memory of Eugene I. Baumgartner, who died in August.

4. Established dates for the 1968 Executive Committee and Council meetings.

5. Submitted a list of three names to the State Health Commissioner to serve as the Faculty representative on the Advisory Council to the Regional Medical Programs, from which the Commissioner will select one. This representative would replace J. Morris Reese, M.D., who declined to serve.

6. Authorized an appointment or designation of a physician to organize a recruiting nucleus of physicians to recruit Volunteer Physicians for Vietnam.

7. Authorized the mailing of a letter to be signed by the Faculty president urging members to purchase U.S. Savings Bonds.

8. Agreed to consider the holding of business sessions of the statewide specialty groups at the time of the annual Faculty meeting (Wednesday, April 17, 8:00 a.m.) only if requested to do so by the Specialty groups.

9. Recommended reappointment of Rachel K. Gundry, M.D., to the Advisory Council on Mental Hygiene.

10. Submitted a list of three names to the State Board of Health and Mental Hygiene for possible appoinment to the Medical Advisory Comittee to Maryland's Medical Assistance program. One name would be selected as a replacement for Dr. Baumgartner.

11. Instructed the staff to bill one of the Specialty groups for use of Faculty facilities, in view of the fact that it does not meet Faculty requirements that at least 90% of its members also be members of the Faculty in order to use these facilities at no cost.

12. Approved the minutes of the September 8, 1967, House of Delegates session.

13. Authorized the payment of a $50.00 Honorarium to the speaker at a scientific meeting arranged by prospective members at the Johns Hopkins Medical School Student AMA chapter.

14. Declined to underwrite the payment of travel and hotel expenses for a Subcommittee chairman who wished to attend a meeting in Houston, Texas.

15. Approved Faculty co-sponsorship with the State Department of Mental Hygiene of a Seminar for physicians on Treatment of Alcoholism. The Faculty will provide staff time, and the State Department of Mental Hygiene will underwrite costs of printing and mailing. Ayerst Laboratories will underwrite speakers' expenses.

16. Approved in principle the "mop-up" measles immunization program to be conducted through the public schools.

17. Endorsed the Diabetes Detection Drive, November 12-18, with the understanding that local participation will be at the discretion of the local component societies.

18. Deferred action on a request for endorsement in principle of a reportable disease law, with the Medical Advisory Board, Department of Motor Vehicles to establish the diseases and conditions and manner of reporting.

19. Authorized payment of "honorariums" to speakers who might give a "name" lecture at the cruise convention, in addition to the cruise convention allowance offered to speakers.

20. Approved contents of a letter to be mailed through Faculty facilities.

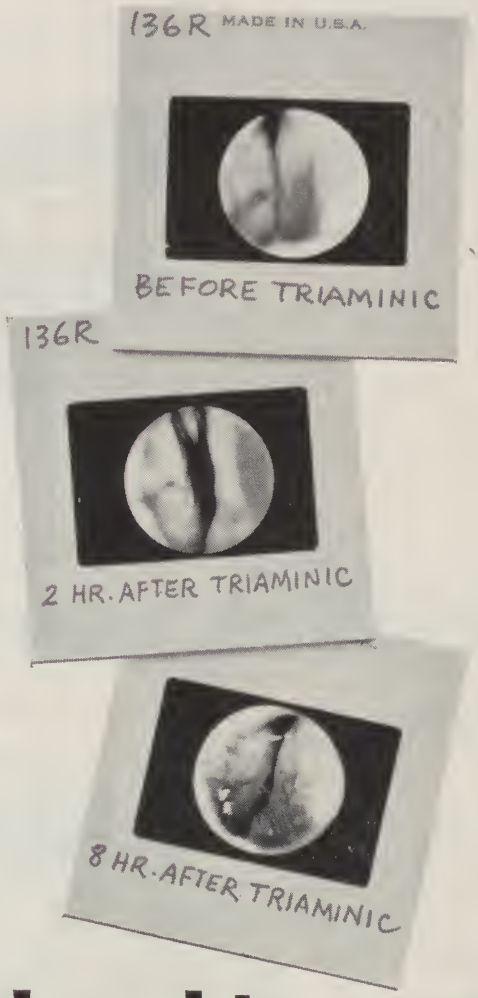
21. Requested that an ad for a physician to work in a "closed panel" medical practice be clarified before it could be carried in the Journal.

22. Authorized appointment of a Faculty representative to the Health and Medical Services Committee of the Maryland Commission on Aging.

23. Authorized representatives of the Faculty to attend an AMA conference on Health Care of the Poor, December 15-16, 1967, in Chicago.

24. Heard a report from the chairman of a discussion held with state government officials in connection with Cancer Cytologies.

From a continuing study on nasal congestion . . .



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A study being conducted by the Department of Otolaryngology, Greater Baltimore Medical Center is stockpiling evidence that points to the fast action and prolonged relief effected by Triaminic in the treatment of nasal congestion.

Begun in March 1966, the study to date has encompassed 85 patients with common nasal disorders—and measured their response to recommended doses of Triaminic tablets.

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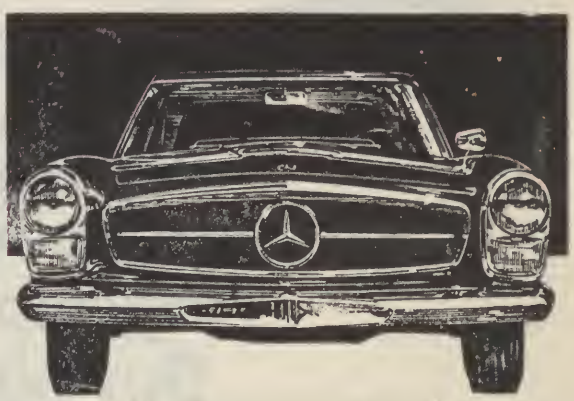


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Mano Swartz

EXECUTIVE SECRETARY'S NEWSLETTER

November, 1967

1968 DUES BILLS

1968 Dues bills are scheduled to be in the mail in late November and early December. Physicians are reminded that payment of dues must be made BEFORE JANUARY 31, 1968 in order to be eligible for Physicians' Defense.

The Council has ruled that strict interpretation of the Faculty's Bylaws will preclude authorization of this benefit of membership if members do not comply with this Bylaw requirement.

ANNUAL MEETING RESOLUTIONS

Deadline for submission of resolutions for consideration at the Faculty's Annual Meeting, April 17 - 19, 1968, is

WEDNESDAY, FEBRUARY 21, 1968

Resolutions received in the Faculty office after that date may not be considered at the Annual Session.

Members are reminded of the recent Bylaw change requiring resolutions introduced by individual members to have the endorsement of either one-third of his component society membership or 30 members of his component society, whichever is smaller.

NEWS NOTES

Thomas H. Powell, M.D., Baltimore, is presently serving in the Volunteer Physician for Viet Nam program. Dr. Powell is an orthopedic surgeon.

Junior Fellows of the American Society of Anesthesiologists are: Drs. Gary G. Gilbert, Arsenio S. Soriano, Jr., and C. R. Wheeless, all of Baltimore.

New Fellows of the same group include Charles G. Battig, M.D., of Bethesda.

OPINION RESEARCH SURVEY

The Illinois Medical Society, in a recent Opinion Research Survey conducted on behalf of the Society, learned that:

ILLINOIS MEDICAL SOCIETY LEARNS ABOUT ITSELF

60% of the GP's regard their State Society membership as valuable, compared to only 49% of the Specialists. Non-metropolitan members valued their membership more highly than metropolitan members.

The younger physicians - comprising the largest group of dissenters - charged the State Society had nothing to offer them. They claimed the State Society ignored the unique problems they are facing, (teaching them the business side of medicine; familiarizing them with services offered).

In other questions, the Society learned that 75% of the membership were not aware of services offered; had no time for ISMS affairs; BUT 90% of those members who used the services of ISMS considered their membership VERY valuable.

Physicians who participated in society activities were among the most enthusiastic of the Society's supporters, claiming they found their committee work satisfying and important.

HAVE YOU VOLUNTEERED YOUR SERVICES LATELY?

1968 CRUISE CONVENTION

Accommodations are still available for the 1968 Cruise Convention leaving Baltimore on the SS Argentina on Sunday, April 21, and returning on April 28. Scientific sessions are planned for each day on board ship. The cruise convention is part of the Faculty's 1968 Annual Meeting scheduled for April 17 - 19, in Baltimore.

Information and reservations may be obtained by calling Travel Guide Agency, SA 7-0682

John Sargeant

Executive Secretary

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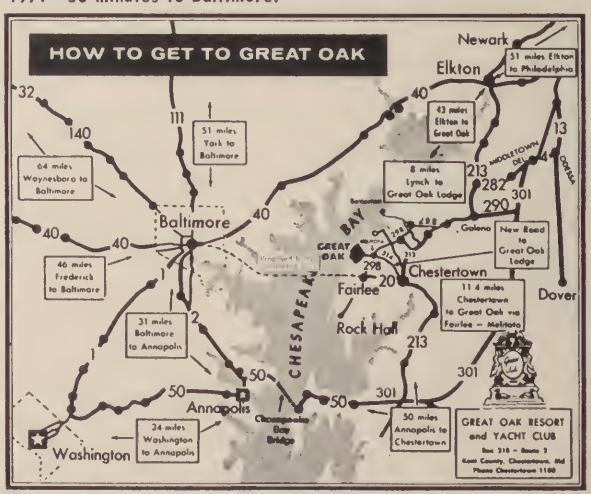
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Dotted line on map indicates proposed bridge to be completed 1971—30 minutes to Baltimore.





John Sargeant
Executive Secretary

John Sargeant, Executive Secretary, came to the Medical and Chirurgical Faculty, in 1958, after an extensive management study pointed up the need for a paid, full-time executive to operate the many facets of Faculty business activity. Prior to joining the Faculty, he had spent five years in a similar post with the Broome County (N. Y. State) Medical Society.

Active and hard-working, "Jack" as he is known to most Faculty members, makes a point to visit with each Component Medical Society at least once a year to acquaint their membership with the latest Faculty activity. In addition, he acts as Legislative Representative during sessions of the State's General Assembly and at meetings of the Legislative Council, the between-sessions group of the General Assembly.

If you have a question on any matter he is the person to whom you should turn for the answer.

Faculty Staff Biographies

"Joe" as he is known to one and all, is directly responsible for all of the Faculty's financial affairs, membership records and Members' Insurance problems. He joined the Faculty in 1963, coming here from a series of positions with ever-increasing responsibilities. A distinct asset to the Faculty operations, he has and is supervising the many improvements towards eventual complete mechanization of the statistical financial and membership operations of the Faculty.



Joseph J. Harrison



Anna Wynde Leake



Eleanor Happel

Administrative Staff

This group of charmers are what make the wheels go around at the Faculty office. Each in her own way contributes to the essence of an efficiently run office. In staffing meetings, fielding inquiries,



June Miller



Karen Clagett



Constance Galton



Genevieve Ritchie

Administrative Staff

preparing reports and performing the multifarious duties that come from actions taken by Faculty Committees, they perform an indispensable function for the Faculty.



Mary Sue Gladden



Bernadette Silk



Beverly Capistrano

Financial and Statistical Staff



Anna Mae Kammer

Doing the detailed work required for membership records, financial statements and paying Faculty bills are these three young ladies. Working directly under the supervision of Mr. Harrison, they field many of the inquiries that flow into the Faculty office, endeavor to correct any errors that the "gremlins" might make and see to it that adequate and proper data is maintained in our records.



Barbara Welch

Journal

Mrs. Maxine Hall has only been with the Faculty for a short time. During this period she has become directly involved in the many operations, all time-consuming, that go towards publication of the Maryland State Medical Journal each month. Her previous experience includes working as a foreign correspondent for the London Daily Express and Woman's Editor to the *Straits Times* in Singapore. She is an avid breeder of pekinese.



Maxine Hall



Katherine Downey

Insurance Trust

Mrs. Katherine Downey heads up the details of operation involved in the Med-Chi Insurance Trust. The program started a brief two years ago, has grown and continues to grow in providing across-the-entire-field of insurance needed by physicians. Mrs. Downey has the information of all insurance programs at her finger-tips and can advise, assist and answer all questions posed to her.

Custodial Staff



Ellen Gordon



Laura Mae Frazier

Behind the operation of the Faculty building is an unseen force of people who see that things are operating properly, that the building is open, well-lit, clean and pleasant to enter. These are the people who do this; as well as handle many, other numerous chores that often go unseen and unsung.



Reuben Parker

Evelyn Dyson



Mary Dixon





Elizabeth Sanford

During the day-to-day operations of the Faculty library, literally dozens of questions are posed to those responsible for such operation. Mrs. Elizabeth Sanford is currently involved in an extensive survey of all the library holdings and with expert advice is presently weeding "out-of-scope" material, reevaluating many of the out-of-print books and rare books that are currently in the circulating collection. This, with other changes to modernize and up-date the Faculty library operations, will result in a more efficient and worthwhile operation for all.

Library



Vera Anderson

The bulk of the queries addressed by the public and many physicians are handled by Mrs. Vera Anderson who maintains an enviable poise when the strangest questions are asked of her. Well-groomed, efficient and always on the job, Mrs. Anderson is never at a loss for an answer. When it is not immediately forthcoming, the patient caller will be asked if the information can be obtained and the call returned when it is available.

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IN-SCHOOL MOP-UP VACCINATION PROGRAM FOR MEASLES

The Maryland State Department of Health estimates that some 39,000 school children in grades one through four are still susceptible to measles. An in-school mop-up vaccination program is underway in an effort to immunize these children.

Garrett County was the first county in the State to conduct an in-school measles mop-up in September. Six hundred and five children were vaccinated in 17 schools in two days. A team of State Department of Health personnel assisted the local staff.

Baltimore City began a program in its schools in October.

Thanks to the ground work of the May, 1967 campaign, measles is now well on the way to being eliminated as a public health problem in Maryland. A successful mop-up program, surveillance, and continuing routine immunization of all one year olds will assure a measles-free community.

* * * * *

MARYLAND, DISTRICT OF COLUMBIA INTERNISTS PLAN FOR SCIENTIFIC MEETING

Specialists in internal medicine in Maryland and the District of Columbia will hold a scientific regional meeting in Baltimore, Md.

The meeting is one of some 35 scientific-educational meetings the *ACP* sponsors during the academic year. Held throughout the United States and Canada, the meetings help the College's 13,600 members keep abreast of developments in the basic sciences and clinical medicine.

Among special guests will be James W. Haviland, MD, Seattle, Wash., Clinical Professor of Medicine at the University of Washington, and Edward C. Rosenow, Jr., MD, Philadelphia, Pa., Executive Director of the American College of Physicians.

Martin L. Singewald, MD, Baltimore, Md., Associate Professor of Medicine, Johns Hopkins University School of Medicine and *ACP* Governor for Maryland and the District of Columbia, is in general charge of the meeting.

The American College of Physicians (Maryland/District of Columbia Regional) Baltimore, Md., Dec. 2, 1967. Info: Martin L. Singewald, MD, 11 E. Chase Street, Baltimore, Md.

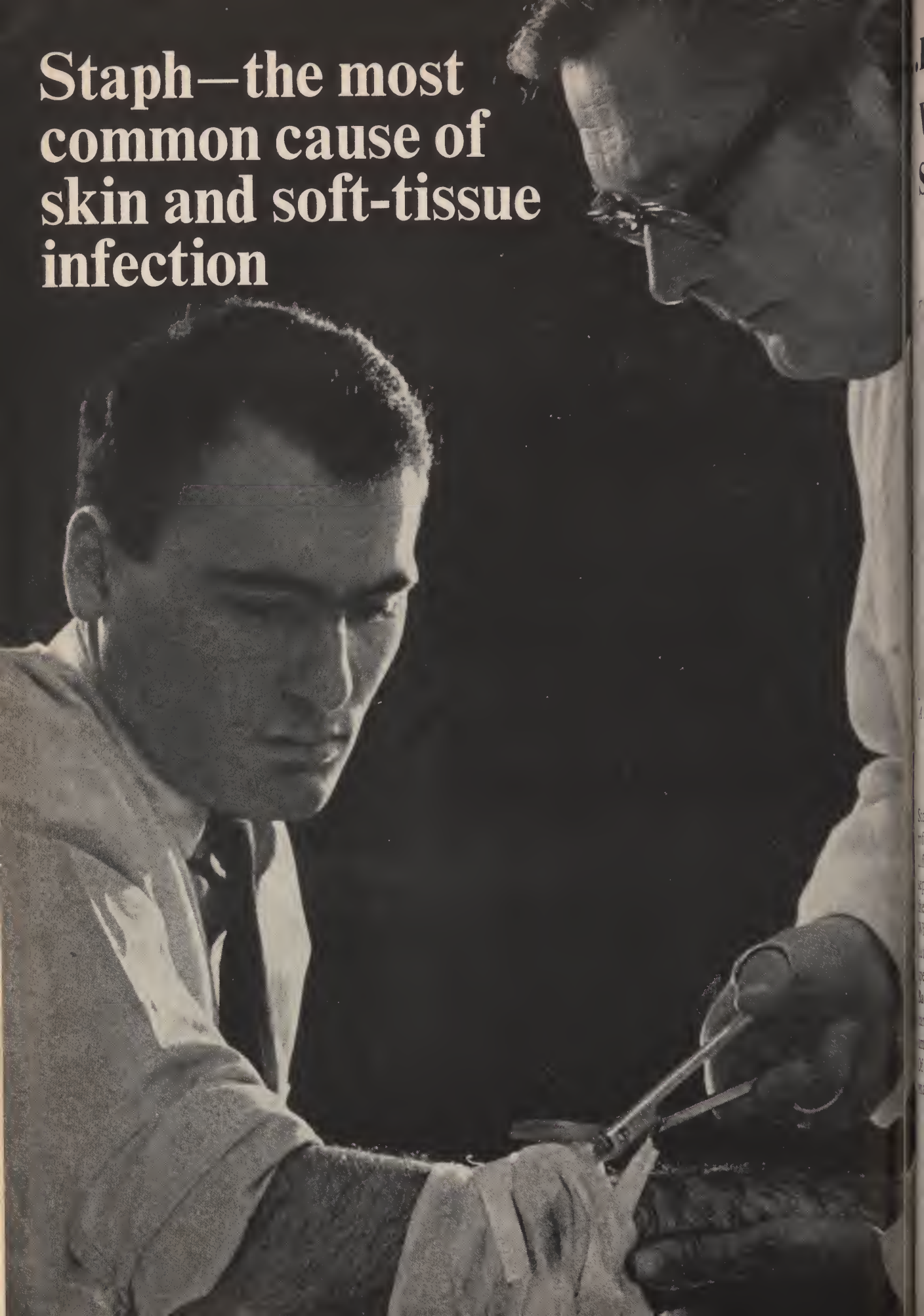
* * * * *

NEW FELLOWS ELECTED

New Fellows of the American College of Surgeons were elected at the annual five-day clinical congress of the world's largest organization of surgeons. Those from Maryland included the following: Drs. H. Logan Holtgrewe, Annapolis; Drs. Arthur Baitch, Salvatore J. DeMarco, III, Ronald H. Fishbein, George H. Greenstein, John E. Hoopes, August Daniel King, Jr., Robert B. McFadden, Albert C. W. Montague, David Paton, Louis E. Queral, Geary L. Stonesifer, Jr., Alvin P. Wenger, Robert E. Zadek, Alberto Zapata, all of Baltimore City; Julius S. Piver and Joseph F. Schanno, of Bethesda. Also, Drs. Robert J. Thomas, Frederick; Francis D. Fowler, Marlow Heights, George J. Ellis, Jr., James P. McCarrick, and Daniel Powers of Rockville; and Drs. Robert E. Collins, J. William Costello, Lloyd H. Scribner and Perry Tirschwell all of Silver Spring.

Fellowship, a degree entitling the recipient to the designation, FACS, is awarded to those surgeons who fulfill the comprehensive requirements of acceptable medical education and advanced training as specialists in one or another of the branches of surgery and who give evidence of good moral character and ethical practice.

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Clinically proven. There is a high correlation between these *in vitro* findings and clinical results. Of 610 patients treated with Prostaphlin (sodium oxacillin), 89.8% were reported cured or improved, including those with staph infections resistant to penicillin G.[2] And since resistance does not appear to develop *in vivo*, therapy with oxacillin can be extended when necessary.

Outstanding safety record. Besides being staph-specific and rapidly absorbed—Prostaphlin (sodium oxacillin) has established an outstanding record of safety during five years of widespread clinical use. Continuous high blood levels of oxacillin have not produced toxic effects on kidney function, assuring a significant margin of safety. However, as with all penicillins, the possibility of allergic response should be considered.

Capsules, Oral Solution and Injectable. Prostaphlin (sodium oxacillin) is available in three flexible dosage forms to suit the age of the patient and severity of infection—capsules, an oral solution for pediatric use, and multi-dose vials for injection, I.M. or I.V.

PRESCRIBING INFORMATION: For complete information, consult Official Package Circular. *Indications:* Infections caused by Staphylococci, particularly those due to penicillin G-resistant Staphylococci. *Contraindications:* A history of severe allergic reactions to penicillin. *Precautions:* Typical penicillin-allergic reactions may occur. Safety for use in pregnancy and premature infants is not established. Because of limited experience, use cautiously and evaluate organ system function frequently in neonates. Mycotic or bacterial superinfections may occur. Assess renal, hematopoietic and hepatic function intermittently during long-term therapy. *Adverse Reactions:* Skin rashes, pruritus, urticaria, eosinophilia, nausea, vomiting, diarrhea, fever and occasional anaphylaxis. Rare cases of reversible hepatocellular dysfunction have occurred. Moderate SGOT elevations have been noted. Thrombophlebitis has occurred occasionally during intravenous therapy and leukopenia was noted in two cases. *Usual Oral Dosage:* Adults: 500 mg. *q.*4 or *q.*6*h.* Children: 50 mg./Kg./day. *Usual Parenteral Dosage:* Adults: 250-500 mg. *q.*4 or *q.*6*h.* Children: 50 mg./Kg./day. Treat beta-hemolytic streptococcal infections for at least 10 days. Give oral drug 1 to 2 hours before meals. *Supplied:* Capsules—250 and 500 mg. in bottles of 48. Injectable—250 mg., 500 mg., and 1 Gm. dry filled vial for I.M./I.V. use. For Oral Solution—100 ml. bottle, 250 mg./5 ml. when reconstituted. **A.H.F.S. CATEGORY: 8:12.6**

References: 1. Abstracted from *Antibiotic Sensitivity of Staphylococci Studied from November 1962 through August 1965*, reported by Griffith, L.J., Staphylococcus Reference Laboratory, V.A. Hospital, Batavia, N.Y. 2. Data on file, Bristol Laboratories.

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Meanwhile, the *existing* Taylor Manor *family* and *facilities* have been and are continuing in *full operation*.

The *presentation*, formal *dedication*, and *showing* for the medical profession is planned for **APRIL 7, 1968.** Please save this Sunday. Invitations will follow.

Edith L. Taylor
Executive Director

Irving J. Taylor, M.D.
Medical Director

From Washington

GENERIC VS. BRAND NAME CONTROVERSY

The controversy over generic vs. brand name drugs was aired at hearings of the Senate Finance Committee and the Senate Small Business Monopoly Subcommittee.

Chairman Russell B. Long (D.,La.) of the Finance Committee planned to offer an amendment to the Social Security bill, which includes *medicare* and *medicaid* changes, to put the emphasis on generic drugs in government medical programs. The monopoly subcommittee, headed by Sen. Gaylord Nelson (D., Wis.), was investigating drug pricing policies with the same objective as Long's proposal.

Long's proposal included the creation of a federal panel to select the highest quality but lowest cost prescription drugs for which patients would be reimbursed under government medical programs.

Both the Food and Drug Administration and the drug industry opposed establishment of such a committee and national formulary of drugs.

FDA Commissioner James Goddard, MD, said it would result in "an encroachment on the practice of medicine in such a way that I believe the physicians of this country would rise up in wrath." He also said:

"In essence the bill would impose upon the formulary committee the duty of evaluating every prescription drug used in medical practice today—more than 5,000—and of providing a formulary of the drugs of choice. I would have to exclude drugs deemed unnecessary, therapeutically duplicative, or of unacceptable quality. The enormity of such a task should be borne in mind."

C. Joseph Stetler, president of the Pharmaceutical Manufacturers Association, joined Goddard and John W. Gardner, Secretary of Health, Education and Welfare, in urging that action on the matter be postponed until a report is made on a special study being conducted by *HEW*. The report is due Dec 1.

Stetler said the drug industry recognizes the government's responsibility to control federal expenditure in its drug purchase programs. But, he said, Long's proposal would put such a low ceiling on drug prices that it would "jeopardize the ability of quality, research-oriented pharmaceutical companies to perform effectively."

"The health of all of us and of future generations is dependent on the continued growth and vitality of a progressive and successful pharmaceutical industry," he said.

* * * * *

GARDNER ON ALCOHOLISM

No other national health problem has been so seriously neglected as alcoholism, according to John W. Gardner, Secretary of Health, Education and Welfare.

"The atmosphere of moral disapproval surrounding the entire subject, and the deplorable custom of treating alcoholics as sinners or criminals have obscured the nature of the problem," Gardner said in connection with a report issued by the National Institute of Mental Health.

The *NIMH* report, titled "Alcohol and Alcoholism," reviews present knowledge of alcohol, the nature and extent of drinking problems; the identification, treatment and prevention of alcoholism, and the status of current research.

Although alcoholism obviously does not occur without alcohol, the report states that "alcohol can no more be considered the sole cause of alcoholism than marriage can be considered the sole cause of divorce, or the tubercle bacillus the sole cause of tuberculosis."

On the treatment of alcoholism, the report says:

"In the past, alcoholics have been admonished, scolded, denounced, jailed, beaten, ducked, lashed, and threatened with eternal damnation. There is no evidence that any of these measures has had significant therapeutic value for more than an occasional alcoholic. Available evidence seems to demonstrate that long-lasting results can be achieved primarily by a technique known generally as psychotherapy."

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POSSIBLE INCREASE MEDICARE PHYSICIANS' FEES

The federal government is planning on increasing the monthly *medicare* insurance rate for physicians' services for next year and 1969.

The present rate is $3 a month. The *medicare* law designated Oct. 1 as the deadline for setting the rate for 1968 and 1969 but Congress approved legislation postponing the announcement until Dec. 31.

John W. Gardner, Secretary of Health, Education and Welfare disclosed a possible increase from $3 to $4 in a letter to Sen. John J. Williams, Del., ranking *GOP* member of the Senate Finance Committee.

The monthly premium is paid by persons 65 and older who elected to get benefits under Part B of the medicare program providing physician services.

"I would promulgate a rate of $3.80 for the two-year period of 1968 and 1969, 25 cents of the increase being based upon our revaluation of the extent to which we believe the premium rate was below the actual cost for 1966-67 and 55 cents being the estimated additional cost to be expected from an estimated increase in utilization and in physicians' fees," Gardner said.

AMA ON PUBLIC HEALTH SERVICES

The *AMA* urged that Congress precisely define "public health services" to prevent the so-called "Partnership in Health" legislation being used as authority for unlimited expansion of government medicine.

In a letter to Chairman Lister Hill (D-Ala.) of the Senate Committee on Labor and Public Welfare, F. J. L. Blasingame, MD, executive vice president of the *AMA*, said:

"We are especially concerned with a lack of definition with respect to comprehensive public health services. Neither 'comprehensive' nor 'public health services' is defined in the law or the bill. While we recognize there is supportable advantage in removing strict categorization of grant funds, we are concerned that the categorical identification having been removed, there will no longer be any limitation on the health care which may be provided. Indeed, from testimony on this legislation by government officials, it would appear that our concern is justified. It is the intent that the Congress is authorizing a program of *individual treatment* for *unidentified patients* for *unspecified conditions* for *unlimited services?* It is clear that the lack of definition of 'public health services' is, in effect, an invitation from Congress to unlimited expansion of 'public health' beyond its traditional role in the community.

"The *AMA* has supported, and continues to support the furnishing of public health services. We have also supported flexibility of operation within the state and local health departments as an effective tool for community health. We feel, however, that the distinction between the public and private health sectors should be delineated . . . in more positive terms than the mere prohibition against interference with the existing patterns of private professional practice. . . . Accordingly, the Association finds itself unable to support this portion of the legislation providing for an undefined program of comprehensive public health services."

The *AMA* also opposed a provision for federal licensure of clinical laboratories on the ground that licensing of such facilities traditionally has been a state matter.

"We believe that federal licensure of these facilities would establish an undesirable precedent," Dr. Blasingame said.

* * * * *

From Chicago

NEGROES FOR MEDICINE

A national awards program to encourage more Negroes to study medicine is a recommendation of a conference report in the current Oct. 16 *Journal of the American Medical Association.*

There also should be major efforts to strengthen the teaching of premedical sciences and English at the predominantly Negro colleges, and to "salvage Negro applicants" who lack certain qualifications for medical school entrance, the report said.

The report is from a conference last June, sponsored by the Josiah Macy, Jr., Foundation,

New York City, with the cooperation of National Medical Fellowships, Inc.

Negroes represent "one of the large untapped sources of personnel for medicine," the report pointed out.

Negroes constitute 11.4 per cent of the US population, but only 2.2% of the nation's physicians.

Only 6% of college-age Negroes attend college, and more than 50% are in the predominantly Negro colleges. In these institutions, the dropout rate averages over 50%.

Well over 50% of Negro college students, but less than 10% of Negro medical students, are women. These women represent "a great potential source of Negro medical school applicants," the report said.

Other recommendations:

The two predominantly Negro medical schools should establish premedical programs—Howard with the liberal arts college of Howard University, Washington, DC, and Meharry with its neighbor, Fisk University, Nashville, Tenn.

Each medical school "should move aggressively" to salvage Negro applicants who are not adequately qualified for the study of medicine. Programs should be established for these students at a liberal arts college, and then continued support provided at medical school.

Special two-year medical schools to prepare students for careers in medicine as well as the other health professions were considered "worthy of careful study." Two-year schools should develop as joint efforts between Negro colleges or universities and medical schools that are able to supply a strong faculty, the report said.

The Negro has special problems in the study of medicine, the conference recognized.

"Moving from the campus of a predominantly Negro college to a medical school in which practically all of the other students and the faculty are white presents severe social problems which, when combined with marginal preparation, may prove too much for the student."

The Negro student should receive sufficient support from the administration, the faculty, and especially his classmates, the report said.

It might be advisable to spread the work of the freshman year in medical school over a longer period, the conference suggested. Special summer programs might allow students to test their abilities in a single course, such as anatomy, and at the same time acquire a sense of security in the environment of the medical school.

"In all discussions, the mood of (conference) participants indicated that there should be a significantly larger number of Negroes in medicine, that there are programs that can prepare larger numbers of Negroes for the study of medicine, and that these programs should be established now," the report said.

The authors are John Z. Bowers, MD, Lee Cogan, MA, and E. Lovell Becker, MD, of the Macy Foundation staff, New York.

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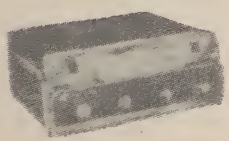
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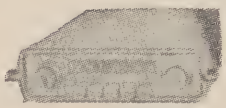
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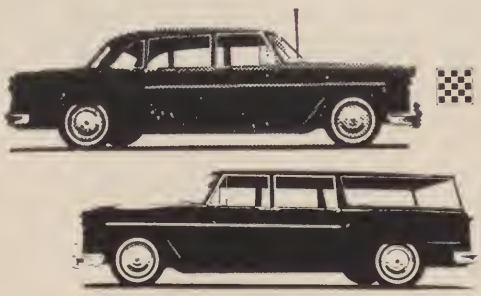
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Book Reviews

PERSPECTIVES IN EXPERIMENTAL GERONTOLOGY, Nathan W. Shock, Ph.D.; Charles C Thomas, Springfield, Ill.

The goal of this book is to present an overview of ideas in the field of experimental gerontology, with emphasis on ideas and experiments. It represents, therefore, more a collection of essays than a detailed summary of all the factual data on specific problem areas.

Well organized throughout, it is not, however, by any means as complete as it might be. Space limitations required the "leaving out" of certain areas. Nonetheless, it is well worth adding to your library.

MENDELIAN INHERITANCE IN MAN, Victor A. McKusick; The Johns Hopkins Press, Baltimore, Md.

This publication is primarily a catalogue of the autosomal dominant, autosomal recessive and X-linked phenotypes. For the first time it utilizes the computer system for assemblying and the "print-out" from such system for the publication of this book. As a reference book it is an excellent addition to the medical library.

CLINICAL MANAGEMENT OF BEHAVIOR DISORDERS IN CHILDREN, Harry Bakwin, MD, and Ruth Morris Bakwin, MD; W. B. Saunders Company, Philadelphia.

This volume is a distillation from a large amount of literature and from the long and careful experience of the authors, of those data that are most helpful in understanding and treating behavior problems in children. This is the third edition of this publication and it is comprehensive, practical and full of common sense. The gratitude of all pediatricians, child psychiatrists and parents should be rendered to them for such a clear and concise job of medical writing.

THE BIOSOCIAL BASIS OF MENTAL RETARDATION, Sonia F. Osler, Ph.D., and Robert E. Cooke, MD; The Johns Hopkins Press, Baltimore, Md.

This collection of various lectures dealing with mental retardation was prepared because of the heavy demand for such information. It is a direct result of a seminar course at the Johns Hopkins University School of Medicine established in 1960. It is an attempt to bring to students of medicine the most recent scientific developments in a field of great national concern. The publishers and authors have done well.

THE THEORY AND PRACTICE OF PSYCHIATRY, Frederick C. Redlich, MD, and Daniel X. Freedman, MD; Basic Books, Inc., New York.

This thoroughly modern text is firmly rooted in history. No area of psychiatry is allowed to go by default, yet no single attitude is allowed to dominate. It is balanced, accurate and well-documented. It is a source book for case-centered observation, for clinical debate and for academic discourse.

ROENTGENOLOGIC DIAGNOSIS, J. George Teplick, MD, Marvin E. Haskin, MD, and Arnd P. Schimert, MD; The W. B. Saunders Company, Philadelphia, Pa.

The organization of this volume provides a new approach in that it is an atlas of the roentgenologic appearance of diseases in their various phases of onset, progression, and complication, together with a graphic description designed to indicate diagnostic highlights.
It is prepared primarily for practicing physicians and for residents in Internal Medicine and Radiology as a guide to diagnostic determination. With 2,000 illustrations it is a worth-while publication to have in many doctor's offices, as well as medical libraries.

DIABETES MELLITUS, DIAGNOSIS AND TREATMENT, VOLUME II, George J. Hamwi, MD, and T. S. Danowski, MD; American Diabetes Association.

This book is useful to practicing physicians as a general manual and equally useful as a textbook and reference resource for students, physicians-in-training, and for instructors.
It is one of a series undertaken by the Association's Committee on Professional Education to make available in highly condensed form the current thinking of a large group of authorities on the principle problems associated with diabetes mellitus. The work of 47 authors is included in this present volume.

LEARNING MEDICAL TERMINOLOGY STEP BY STEP, Clara Tene Young and James D. Barter, MD; The C. V. Mosby Company, St. Louis.

This 1967 edition is a complete revision of the earlier 1964 edition. It presents a logical, organized, step-by-step method for unlocking the mysteries of medical terms and for building a workable medical vocabulary applicable to all specialties of medicine. It is particularly designed to facilitate the training of paramedical personnel to meet the increasing demands for trained workers in doctor's offices, hospitals, insurance and medicolegal firms and local, state and federal medical installations.

HOMOTRANSPLANTATION, by Jack Metcoff, MD; National Kidney Foundation, New York City.

The proceedings of the 16th annual conference on the kidney, held in 1964, is compiled in this book. It brings the reader up to date on the problems of tissue transplantation with particular reference to the kidneys. Under the sponsorship of the National Kidney Foundation, the conference is an annual event well-attended by those persons particularly interested in this subject.

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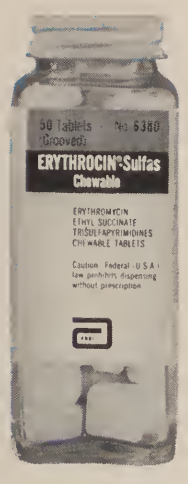
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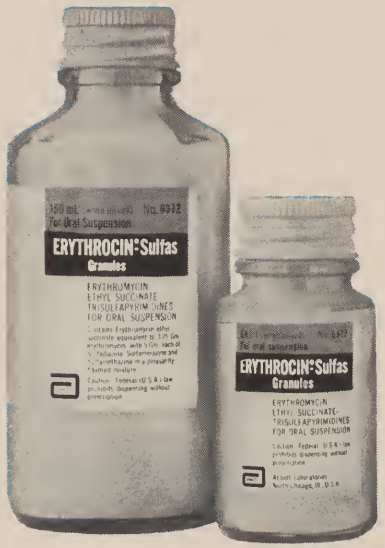
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Perhaps there have been times when you wanted to prescribe erythromycin and triple sulfas for little patients. Now you can—with a choice of two new fine-tasting pediatric forms.

New–Two Pediatric Forms of Erythromycin and Triple Sulfas





ERYTHROCIN®-SULFAS Chewable (Erythromycin ethyl succinate-trisulfapyrimidines chewable tablet)

In clinical trials[1,2], this orange-flavored tablet was given to 55 patients, aged four months to 18 years.

Diagnoses (multiple in some cases) represented a cross section of bacterial infections commonly seen in pediatric office practice.

Therapy was given from three to 12 days, with an average of six days.

Of the 55 patients, 30 were reported cured within 72 hours, while 22 showed partial recovery within the same time, and subsequent clinical cure.

A clinical cure rate of 94.5%

ERYTHROCIN®-SULFAS Granules (Erythromycin ethyl succinate-trisulfapyrimidines granules for oral suspension)

87 patients were treated[1,2]—all children, ages four months to 15 years.

The diagnoses were multiple in some cases and were chiefly bacterial infections of the respiratory tract.

Dosage was maintained from three to 10 days; average treatment was five days. All of the ill children accepted the orange-flavored suspension favorably.

53 were clinically cured within 72 hours, while 32 showed partial relief within the same time, and subsequent clinical cure.

701358

A clinical cure rate of 97.7%

1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

ABBOTT

Brief Summary on next page

ERYTHROCIN®-SULFAS
Brief Summary

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or newborn infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. of each of sulfadiazine, sulfamerazine and sulfamethazine.

701358

ABBOTT

EXECUTIVE HEALTH EXAMINATIONS

Determination as to ethics made by The Mediation Committee, Medical and Chirurgical Faculty of the State of Maryland, September 25, 1967:

Health Evaluation Groups—Independent or Hospital affiliated

1. Many firms have arranged for a program of periodic health evaluation of key personnel by medical groups specializing in this service. In many cases the employe must sign a prior authorization for release of the findings to the company. It is desirable, and the committee urges, that, with the employe's consent, a complete copy of the examination be provided to the employe's private physician and, equally important to the company's medical officer if there is one. Such information should not be released to nonprofessional management personnel.

2. More serious, however, is the increasing frequency with which such groups refer patients to specialists for treatment of diseases found on such health examinations. This is not the proper function of such a group and should be referred to the employe's family physician.

2. Last, the active advertising or direct solicitation of new contracts for such services (whether by newspaper articles, direct mailing, etc.) is unethical. It cannot be condoned, regardless of the status of the individual who does so. Professional members of such groups, whether full-or part-time, must accept responsibility for such unethical conduct.

(*a*) Information and publicity are strictly limited (1) to dignified, restrained announcements to local county medical societies, local chapters of the Industrial Medical Association, to professional publications, and, on bona fide request, to industry or to patients, which announcements may properly include the names of professional personnel, types of services available, office hours, address and telephone number; (2) to personal contact by doctors of medicine with their business friends by individual conversation or by personal letter; and/or (3) to such personal contact with medical directors of industrial organizations.

(*b*) The following described activities are not engaged in: (1) mass salesmanship technics in office buildings by doctors of medicine or by business managers, nurses, or other nonmedical personnel or representatives; (2) mass or other circulation of publicity material to industry, except as provided in subparagraph (1) of paragraph D hereof; (3) articles in lay publications, except with the written prior approval of the censors of this society; (4) participation in radio or television programs without prior written clearance and approval of the censors of this society; (5) direct solicitation of medical contracts with industries in other cities otherwise than through the local county medical societies or the medical directors of the respective companies; and (6) the establishment or continuance of affiliated organizations or other agencies under lay management and the use thereof for the purpose of soliciting industry.

* * * * * *

COMPONENT MEDICAL SOCIETIES

BALTIMORE CITY

All of the members of the Board of Directors of the Baltimore City Medical Society met on September 5, 1967 at 1211 Cathedral St., Baltimore, Md. This was the first meeting of the Board following the summer vacation. The meeting was called to order by Harry Connolly, MD, President of the Baltimore City Medical Society. The minutes were read and approved for the meeting of June 13, 1967. The first item on the agenda was the consideration of continuing the emergency questionnaire which is sent yearly by the Medical Society. It was decided by the Board that use of this questionnaire should be discontinued at this information could be obtained from the questionnaire soon to be mailed out by the City Health Department. John DeHoff, MD, Director of the local Health Services presented a program for a demonstration project of medical practice and the delivery of medical services with emphasis on office practice. Dr. DeHoff urged the Baltimore Medical Society to take the first steps in formulating such a project, as it is necessary to define the medical needs of the people of Maryland. Dr. DeHoff suggeted that such a project could be funded from the City Society and Public Health Service. Further, he suggested that such a program could be integrated with the surrounding counties. It was his opinion that much valuable information related to the medical facilities available in Baltimore and the surrounding community could be gleaned from such a well designed study. After discussion by the Board, the program was referred to the Policy and Planning Committee for further consideration. Dr. Farber, confirmed his belief in such a program and further stated that the Baltimore City Health Department is sponsoring a simplified version of such a survey to be taken in Baltimore. This survey entails the use of a simple questionnaire which in general answers the question "who is practicing what, and where". This survey is to be kept current and provide an up to date source of information pertinent to the City's medical facilities.

The Board unanimously approved the sponsorship of the survey proposed by Dr. Farber. John C. Harvey, MD, suggested that a letter of explanation be sent with the questionnaire from the President of the Baltimore City Medical Society explaining the necessity of such a survey and urging physicians in practice to cooperate. Frank Kaltreider, MD, emphasized that the Baltimore Medical Society should be active in planning the formulation of the State Planning Council as authorized by PL89-749. Further, he suggested that since this Council is to be the central agency for administering and planning public and private health care facilities, the Medical Society should contact the Hospital Council and that both groups in a combined effort should exert their influence in the planning of this important Council. Frank Furstenburg, MD, suggested that the two existing medical schools should also be included in this group since they will undoubtedly be influenced by policies proposed by this Council. Dr. Kaltreider agreed with this suggestion and proposed that the Baltimore City Medical Society, the Hospital Council and representatives of the two medical schools should meet jointly to discuss medical problems relative to PL89-749. This move was unanimously approved by the Board of Directors. The next item taken into consideration was related to matters of insurance. It was decided by the Board of Directors that the Society should withdraw sponsorship of any program that is already sponsored by the State Medical Society. Further, it was decided that a letter should be sent to Strudwick Associates withdrawing support of group sponsorship of the Northwestern Insurance Company by the Baltimore Medical Society. It was emphasized that participants already enrolled in this program and under contract through such programs should continue in their present status without change. The Board took into consideration the review of job classification for Mrs. Janos. It was agreed that her job classification

Don't let monilia cut broad-spectrum therapy short...

start with Tetrex-F®

tetracycline phosphate complex-nystatin

Use of broad-spectrum antibiotics can cause fungal overgrowth in the alimentary tract... and give rise to symptoms so troublesome that therapy must be prematurely stopped. Tetrex-F (tetracycline phosphate complex-nystatin) helps you circumvent this problem.

The nystatin can prevent overgrowth of monilia; the phosphate complex delivers tetracycline to the blood rapidly. Side effects are infrequent.

High-Risk Patients

Tetrex-F (tetracycline phosphate complex-nystatin) is especially useful in patients most susceptible to fungal overgrowth during tetracycline therapy: (1) the elderly or debilitated, (2) young children, (3) the diabetic, (4) those on long-term tetracycline therapy, (5) those on steroid therapy, (6) those who have had moniliasis before, and (7) pregnant patients with a history of monilial vaginitis.

When you start with economical Tetrex-F (tetracycline phosphate complex-nystatin), you can complete the full course of broad-spectrum therapy with less chance of losing control elsewhere. A good start for a healthy finish.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201

should be changed and her salary adjusted commensurate with the new classification.

The Board reviewed the meeting plans for the forthcoming year, and the year's itinerary for meetings and social events involving the Baltimore City Medical Society and auxiliary groups were agreed upon. The Board of Directors met with Delegates of the State Medical Society for purposes of exchanging ideas relative to the forthcoming meeting of the House of Delegates in Ocean City on September 8, 1967.

Emeritus membership list was reviewed and the following members were accepted in the Emeritus membership category:

Herbert E. Reifschneider, MD.
Isadore M. Siegel, MD.
Thomas G. Prempas, MD.
Arthur I. Fink, MD.
Artur Saar, MD.

The question of changing the present method of handling complaints registered against doctors by a new committee was considered. The Board of Directors felt that these complaints in the past had been adequately handled by the Board and this method of handling such complaints should be continued. Dr. Harry Connolly read a letter from the District of Columbia Computer Billing System. This system is sponsored by The Medical Society of the District of Columbia and entails a cooperative standardized computer billing system. The Board felt that Dr. Connolly should appoint a special committee to investigate this system and possible endorsement by the Society should be contingent upon the findings of this committee. This committee was to be elected by Dr. Connolly in the near future.

Arthur E. Cocco, MD
Journal Representative
From the Baltimore City Medical Society

FREDERICK COUNTY

FREDERICK COUNTY MEDICAL SOCIETY
FREDERICK, MARYLAND 21701

Events That Have Occurred In Our Society

1. Dr. and Mrs. J.G.F. Smith were honored by the Brunswick Lions & Rotary Clubs for 52 years devoted service to the community.
2. Joseph Lerner, MD, resigned and moved to Hawaii.
3. Joseph Burnett, MD, was accepted as Associate Member in our society.
4. Edward Jay Koenigsberg, MD, joined the Pediatric Staff and was accepted as active member in our society in September.
5. Robert Kastner, MD, has been accepted as associate member in our society.
6. Gerald Schipper, MD, changed from active membership to associate membership in our society.
7. Richard Holz, MD, transferred from Baltimore County Medical Society to the Frederick County Medical Society.
8. Robert J. Thomas, MD, was appointed Deputy Medical Examiner for Frederick County upon the resignation of B.O. Thomas, Sr., MD.
9. Lawrence Eanet, MD, was accepted as Associate Member in our society.

Mrs. Rose M. Williard, Executive Secretary
Frederick County Medical Society
Frederick, Maryland 21701

MONTGOMERY COUNTY MEDICAL SOCIETY

"Burst into Fashion"

BENEFIT LUNCHEON AND FASHION SHOW

Wednesday, January 17, 1968

At Indian Spring Country Club
Proceeds to benefit the Medical Allied Scholarships and Loan Programs at University of Maryland and Montgomery County Workshop for the Handicapped
For information: Mrs. Naomi D. Levin, 439-8729, or Mrs. Robert S. Smith, 469-8886

Luxury Apartments in the Heart of Downtown Baltimore

222 SAINT PAUL

at E. Saratoga St.
3 Blocks from
Charles Center



Enthusiastic approval for Baltimore's tallest building (40 stories), towering above the harbor and city skyline, overlooking beautiful Preston Gardens. Just a short walk to work, to the finest shops, restaurants, theatres, cultural and civic events. Efficiencies, one and two bedroom apartments for every taste and budget. All amenities, including swimming pool, 24-hour doorman security, attendant parking.

Decorated Model Apartments Open

Phone 837-5300

Butazolidin®, phenylbutazone
In Acute Superficial Thrombophlebitis

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make regular blood counts. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Purpuric rash has also been reported. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Acute Superficial Thrombophlebitis: Initial: 6 capsules or tablets daily in divided doses for 2 or 3 days. Maintenance: 3 capsules or tablets daily. Usual duration of therapy is 5 to 7 days (rarely beyond 10 days). 6509-V(B)R2

*Stein, I.D.: Presented at the American Academy of General Practice, Dallas, Sept. 1967.

For complete details, please see full prescribing information.

it used to take weeks



Acute superficial thrombophlebitis before treatment



After 5 days of Butazolidin therapy

In acute superficial thrombophlebitis, patients were usually bedfast for 2 to 4 weeks, tying up hospital beds, requiring costly nursing care and time-consuming procedures such as warm soaks and packs.

When Butazolidin was added to the usual regimen, 960 of 1000 patients obtained complete resolution; most required only 30 capsules or tablets; relief of pain and discomfort and regression of inflammatory signs and fever occurred within a few days.*

Side effects occurred in 6% of the 1000 patients. While none were serious or long-lasting, Butazolidin can produce severe side effects in rare instances. Further, not every patient can take Butazolidin. Therefore, select patients with care and follow them closely. Contraindications, Warning, Precautions and Adverse Reactions are summarized in adjacent column.

Butazolidin gets bedfast thrombophlebitics out of bed, fast. Usual duration of treatment is 5 to 7 days, and rarely exceeds 10 days. Try it and see. For full details, please refer to the complete prescribing information.

Butazolidin® alka

Capsules:
phenylbutazone, 100 mg.; dried aluminum hydroxide gel, 100 mg.; magnesium trisilicate, 150 mg.; homatropine methylbromide, 1.25 mg.

Butazolidin®

phenylbutazone

Tablets of 100 mg.

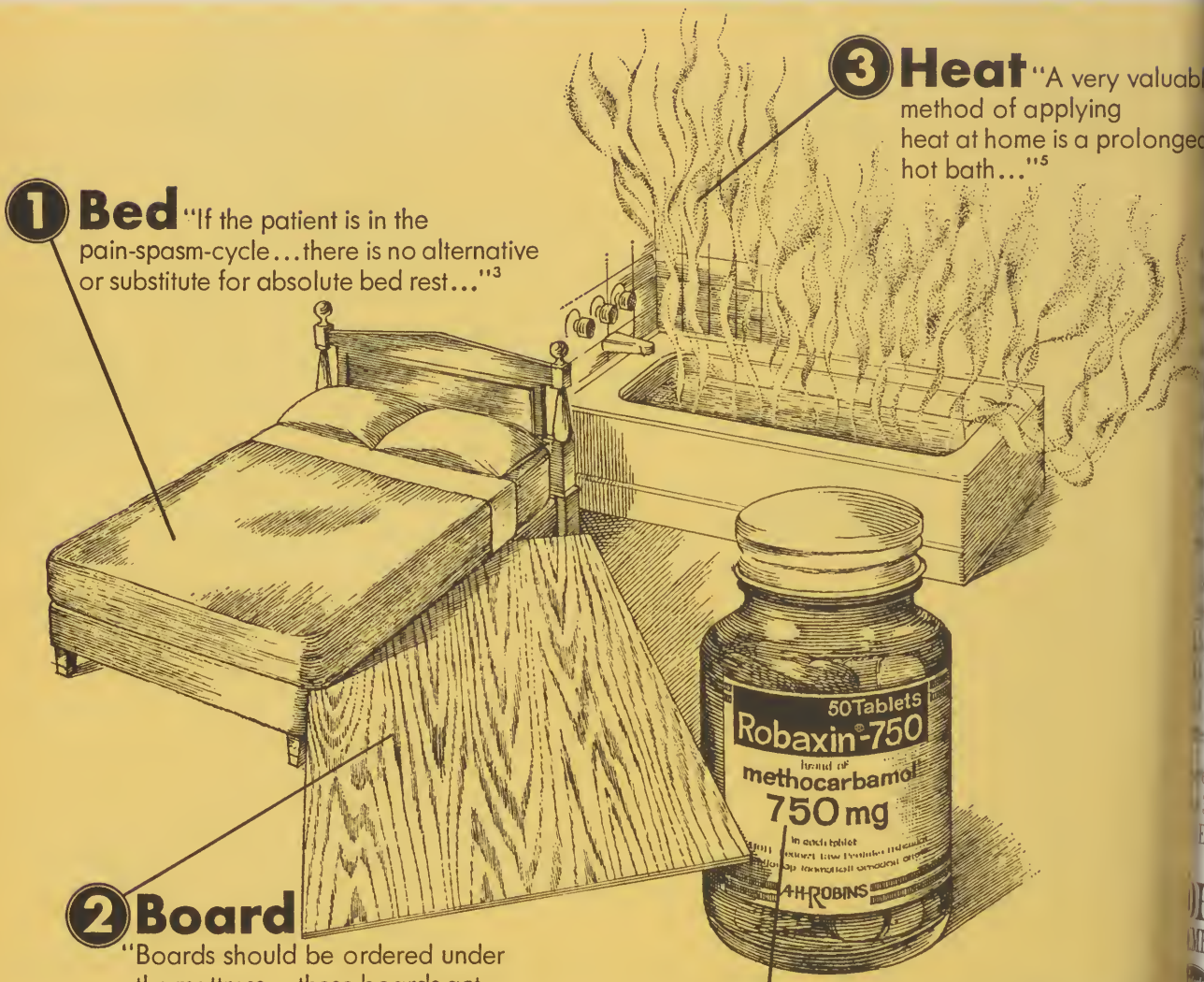
Geigy

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York

LOW-BACK PAIN

A CONSERVATIVE, FOUR-POINT PROGRAM

The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.[1,2] For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:



1 Bed "If the patient is in the pain-spasm-cycle...there is no alternative or substitute for absolute bed rest..."[3]

2 Board "Boards should be ordered under the mattress...these boards act by immobilizing the spine..."[4]

3 Heat "A very valuabl method of applying heat at home is a prolonged hot bath..."[5]

4 Robaxin®-750 (methocarbamol, 750 mg. capsule-shaped tablets) A well-tolerated[6] skeletal muscle relaxant, methocarbamol helps relieve spasm "...without interfering with normal tone and movement."[7] And there is little likelihood of sedation.[6]

Indicated for relief of skeletal muscle spasm. **Contraindicated** in hypersensitive patients. **Side Effects** (lightheadedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently. See product literature for further details. **Also available:** Robaxin® Tablets (methocarbamol, 500 mg.) Robaxin Injectable (methocarbamol, 1 Gm./10 cc.)

References: (1). Godfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gottschalk, L.A.: GP 33:91, 1966. (3). Rowe, M.L.: J. Occup. Med. 2:219, 1960. (4). Cozen, L.: South Dakota J. Med. 18:26, 1965. (5). Soto-Hall, R.: Med. Sc. 14:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteopath. A. 62:142, 1962. (7). Feuer, S.G., *et al.*: New York J. Med. 62:1985, 1962.

A·H·ROBINS A. H. ROBINS COMPANY RICHMOND, VIRGINIA 2322

b.i.d.

The sensible schedule that covers the patient day and night

If our objective in the use of a broad-spectrum antibiotic is prolonged action, with high blood levels, then you know why b.i.d. DECLOMYCIN is considered to be a sensible dosage schedule.

The maintenance dosage of DECLOMYCIN can be kept at this convenient schedule because of its unusually high effective blood and tissue levels.

The b.i.d. dosage of DECLOMYCIN gives you the comfortable assurance that the patient is well-covered, *day and night.*

In clinical practice, blood levels produced by therapeutic dose of DECLOMYCIN are high, prolonged, and effective; because of high serum binding and slow renal clearance. And if there's a broader susceptibility pattern of organisms, we've yet to see it.

There is no need to give higher daily dosage than 300 mg b.i.d., except in venereal diseases and Eaton Agent pneumonia.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Lederle

(Prescribing information on next page.

b.i.d. The sensible schedule that covers the patient day and night

DECLOMYCIN Demethylchlortetracycline should b equally or more effective therapeutically than othe tetracyclines when the offending organisms ar tetracycline-sensitive.

Contraindication: History of hypersensitivity t demethylchlortetracycline.

Warning—In renal impairment, usual doses may lea to excessive accumulation and liver toxicity. Under suc conditions, lower than usual doses are indicated, and, i therapy is prolonged, serum level determinations may b advisable. A photodynamic reaction to natural or artif cial sunlight has been observed. Small amounts of dru and short exposure may produce an exaggerated sun burn reaction which may range from erythema to sever skin manifestations. In a smaller proportion, photo allergic reactions have been reported. Patients shoul avoid direct exposure to sunlight and discontinue dru at the first evidence of skin discomfort. Necessary subs quent courses of treatment with tetracyclines should b carefully observed.

Precautions—Overgrowth of nonsusceptible organism may occure. Constant observation is essential. If new in fections appear, appropriate measures should be take In infants, increased intracranial pressure with bulgin fontanels has been observed. All signs and sympton have disappeared rapidly upon cessation of treatmen

Side Effects—Gastrointestinal system—anorexi nausea, vomiting, diarrhea, stomatitis, glossitis, enter colitis, pruritus ani. Skin—maculopapular and erythem tous rashes. A rare case of exfoliative dermatitis h been reported. Photosensitivity; onycholysis and d coloration of the nails (rare). Kidney—rise in BU apparently dose related. Transient increase in urina output, sometimes accompanied by thirst (rare). Hype sensitivity reactions—urticaria, angioneurotic edem anaphylaxis. Teeth— dental staining (yellow-brown) children of mothers given this drug during the lat half of pregnancy, and in children given the drug duri the neonatal period, infancy and early childhoo Enamel hypoplasia has been seen in a few children. adverse reaction or idiosyncrasy occurs discontin medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 3 mg b.i.d. Should be given 1 hour before or 2 hours af meals, since absorption is impaired by the concomita administration of high calcium content drugs, foods a some dairy products. Treatment of streptococcal inf tions should continue for 10 days, even though syn toms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 given in equally divided doses over a period of 10 to 15 days shoul followed. Close follow-up observation of the patient is recommen including appropriate laboratory tests, since demethylchlortetracyc has not had adequate evaluation in all stages of syphilis. Spinal fl examination should be included as part of this follow-up.

Acute gonococcal anterior urethritis in males has been treated effecti with a single dose of 600-900 mg. of DECLOMYCIN Demethylchlorte cycline. Individuals unable to tolerate large single doses due to ga intestinal side effects may be treated with 150 mg. every 6 hours f minimum of 4 doses or 300 mg. every 12 hours for a minimum of 2 d Females should be treated with a dosage of 150 mg. every 6 hours or mg. every 12 hours until a cure is effected.

Primary Atypical Pneumonia (Eaton Agent): The average adult dosage is 900 mg. in 3 divided doses for six days.

LEDERLE LABORATORIES, A Division o American Cyanamid Company, Pearl River, N

Lederle

485-7—

The AMBAR SCRAPBOOK of

Obesity Oddities

FACT & LEGEND

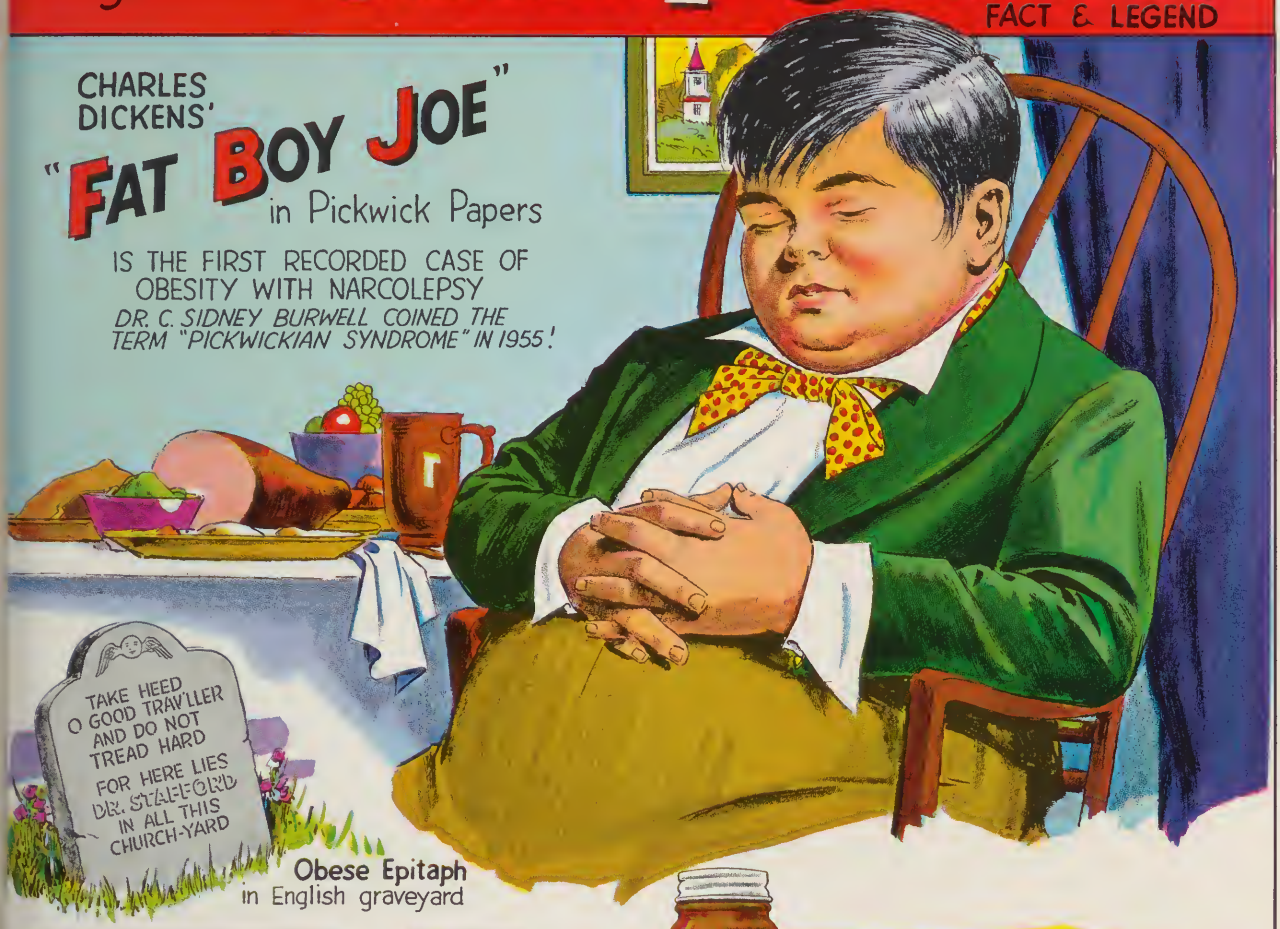
CHARLES DICKENS'

"FAT BOY JOE"

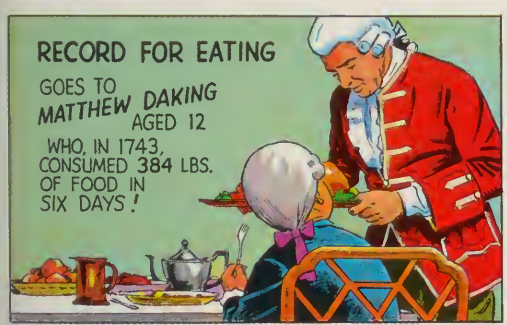
in Pickwick Papers

IS THE FIRST RECORDED CASE OF OBESITY WITH NARCOLEPSY

DR. C. SIDNEY BURWELL COINED THE TERM "PICKWICKIAN SYNDROME" IN 1955!



Obese Epitaph in English graveyard





THE Cost of **AMBAR EXTENTABS**

IS APPROXIMATELY ONE-HALF THAT OF OTHER LEADING APPETITE SUPPRESSANTS.

AN IMPORTANT FACTOR IN LONG-TERM THERAPY!



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety... helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220 A·H·ROBINS



Help clear up that miserable stuffed-up feeling with Dimetapp. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. The key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done... in a hurry.

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220
A·H·ROBINS

in sinusitis, colds, U.R.I.
Dimetapp® Extentabs®

(Dimetane® [brompheniramine maleate], 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)

up to 10-12 hours clear breathing on one tablet



Night Leg Cramps . . . Unwelcome Bedfellow

In Diabetes[1], Arthritis[2], and Peripheral Vascular Disorders[2]



now . . . specific therapy for night leg cramps

Walker

QUINAMM™

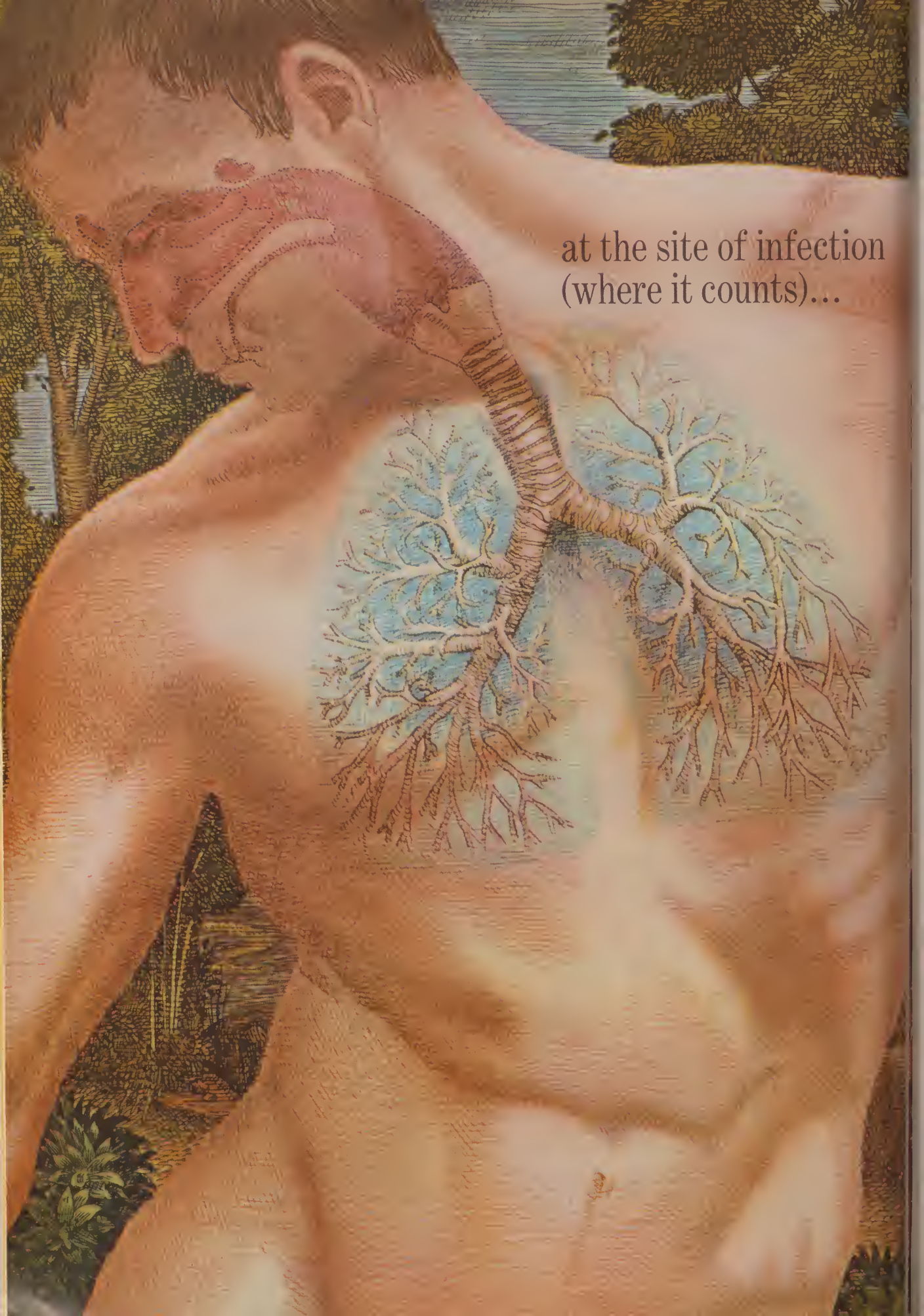
Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.[3] Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.

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DIVISION OF RICHARDSON MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

Prescribing Information: Composition: Each white, beveled, compressed tablet contains: Quinine Sulfate 260 mg. and Aminophylline 195 mg. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

References: 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rawls, W., et al.: Med. Times, 87:818, 1959.

6/67 Q-706A


at the site of infection
(where it counts)...

Ilosone® provides more antibacterial activity than any other oral erythromycin

Acid stable, better absorbed... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food[1-3]

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

Now available:
New! Ready-mixed Ilosone Liquid 125! (Contains erythromycin estolate equivalent to 125 mg. erythromycin base per 5-cc. teaspoonful.)

701464

Ilosone®
Erythromycin Estolate

Lilly

(See next page for prescribing information.)

Ilosone®/the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by micro-organisms sensitive to its action—especially staphylococci, hemolytic streptococci, and pneumococci.

It has been effective in streptococcus infections, particularly acute bacterial pharyngitis and tonsillitis; staphylococcus disease, including soft-tissue infections, furunculosis, abscesses, cellulitis, carbuncles, and wound infections; pneumococcus pneumonia and acute bronchitis with pneumococci on culture, bronchopneumonia, and otitis media.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents; surgical procedures should be performed when indicated, and large doses of the antimicrobial agents should be employed.

Penicillin is the drug of choice for syphilis and gonorrhea, but Ilosone in multiple 500-mg. doses has been useful in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Known history of sensitivity to this drug; preexisting liver disease or dysfunction.

Adverse Reactions: Hepatic dysfunction with or without clinical jaundice has been reported infrequently. Changes in liver function tests indicative of intrahepatic cholestasis appear to be the result of individual idiosyncrasy. Findings subsided when treatment was discontinued. Occasionally, symptoms simulated extrahepatic obstructive jaundice or the colic of biliary tract disease.

When jaundice appeared to be related to use of the drug, laboratory findings were characterized by increased direct-reacting bilirubin, elevated alkaline phosphatase levels, negative or weakly positive cephalin flocculation and thymol turbidity tests, elevated serum glutamic oxalacetic transaminase levels, peripheral eosinophilia, and normal cholecystograms.

Gastro-intestinal disturbances not associated with hepatic effects and occasional allergic manifestations (urticaria, skin eruptions, and, rarely, anaphylaxis) have been reported. The normal intestinal gram-negative bacterial flora is not appreciably altered by erythromycin drugs.

Administration and Dosage: Ilosone is administered orally.

Infants and children under twenty-five pounds, 5 mg. per pound every six hours; twenty-five to fifty pounds, 125 mg. every six hours. Adults and children over fifty pounds, 250 mg. every six hours.

For severe infections, double the dosage. When larger doses are indicated, consider parenteral erythromycin therapy. In beta-hemolytic streptococcus infections, maintain treatment for ten days to prevent rheumatic fever or glomerulonephritis.

In syphilis, a total of 20 to 30 Gm. is administered in divided doses for ten to fifteen days. Close follow-up is necessary since erythromycin drugs have not had adequate evaluation in all stages of syphilis. Examination of spinal fluid is recommended during follow-up.

In gonorrhea, the dosage is 500 mg. four times a day for four days. Patients with a suspected lesion of syphilis should have a dark-field examination before receiving antibiotics and monthly serologic tests for three months. For detailed information, consult the package literature.

How Supplied: Pulvules® Ilosone, Capsules, N.F., 125 mg.* and 250 mg.*

Ilosone Liquid 125, Oral Suspension, U.S.P., 125 mg.* per 5-cc. teaspoonful.

Ilosone, 125, for Oral Suspension, N.F., 125 mg.* per 5-cc. teaspoonful.

Ilosone Drops, 5 mg.* per drop.

Tablets Ilosone Chewable, N.F., 125 mg.*

*Base equivalent. [080967]

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:69, 1964. 2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:398, 1962. 3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 1960.

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

Lilly

701464

Dulcolax®

bisacodyl

DU-5255 R

few drugs work as predictably as Dulcolax. You can expect that when your office patient takes Dulcolax at home, it will be as effective as you said it would be. Your patient will be gratified, too.

The reliability of Dulcolax stems from its unique mode of action. The drug works directly on nerve endings in the colonic mucosa, producing normal peristalsis throughout the large intestine. It does not rely on systemic absorption for its effect.

This reliable action provides prompt relief of constipation. It also makes Dulcolax particularly useful for prepping the bowel for special procedures. In short, it makes Dulcolax ideal for your office practice.



Dulcolax acts so surely that the time of evacuation can often be closely predicted. Dulcolax tablets taken at night almost invariably result in a bowel movement soon after waking the following morning. Dulcolax suppositories generally work in 15 to 20 minutes, almost always within the hour.

General Dosage Information: *Adults:* When an ordinary laxative effect is desired, 1 to 3 tablets or 1 suppository usually suffices. Tablets must be swallowed whole, not chewed or crushed, and should not be taken within one hour of antacids or milk. *Children:* 1 or 2 tablets, depending on age and severity of condition. Tablets must not be given to a child too young to swallow them whole. For infants and children under 2 years of age, half a suppository is usually effective. Above this age whole suppository is usually advisable. Side Effects: As with any laxative, abdominal cramps are occasionally noted, particularly in severely constipated persons. High dosage may result in loose, unformed stools. Contraindication: Contraindicated only in acute surgical abdomen. Availability: Tablets (5 mg.) and suppositories (10 mg.). By prescription or recommendation.

Under license from Boehringer Ingelheim G.m.b.H.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation, Ardsley, N.Y.



"Yes, Doctor, the pain is gone."

'EMPIRIN'® COMPOUND with CODEINE PHOSPHATE gr. 1/2 No. 3

Each tablet contains: Codeine Phosphate gr. ½ (Warning—May be habit forming), Phenacetin gr. 2½, Aspirin gr. 3½, Caffeine gr. ½.

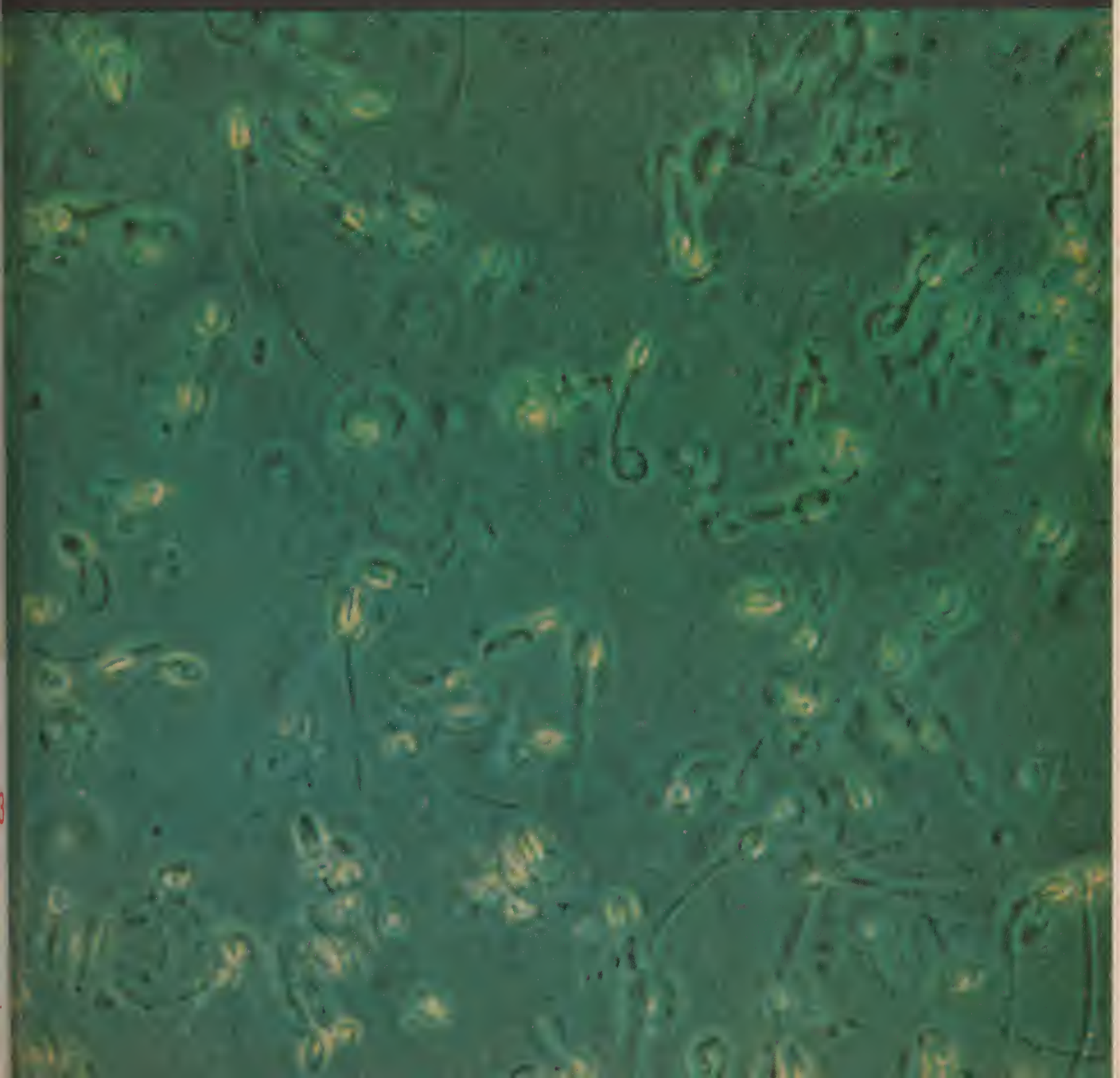
■ Despite introduction of synthetic substitutes, efficacy of 'Empirin' Compound with Codeine remains unchallenged.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg. c mestranol 0.05mg.)

Turn page for contraindications, precautions and side effects.



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Prescribing Information

Contraindications: Patients with any symptoms or history of thrombophlebitis, pulmonary embolism, liver dysfunction or disease, carcinoma of breast or genital organs, or undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. The safety of Norinyl-1 in pregnancy has not been demonstrated. If a patient misses two consecutive periods, pregnancy should be ruled out before continuing the medication. If she has not adhered to the prescribed schedule, pregnancy should be considered at the first missed period. Active ingredients of oral contraceptives have been detected in the milk of mothers who received these drugs; the significance to infants has not been determined.

Precautions: Pretreatment physical should include examination of the breasts and pelvic organs, as well as a Papanicolaou smear. If endocrine or liver function tests are abnormal during therapy, repeat tests are recommended after the drug has been withdrawn for two months. Following administration of drug, preexisting uterine fibromyomata may increase in size. Careful observation and caution are required for patients with symptoms or history of epilepsy, migraine, asthma, cardiac or renal dysfunction, cerebrovascular accident, psychic depression, and diabetes. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Possible long-term effects of the drug on pituitary, ovarian, adrenal, hepatic or uterine function must await further studies. The physician should be alert to the earliest manifestations of thrombophlebitis and pulmonary embolism. The drug should be used judiciously in those young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask symptoms of the climacteric. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following have been observed with varying incider in patients receiving oral contracep tives: nausea, vomiting, gastrointe tinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edem chloasma or melasma, breast chan (tenderness, enlargement and secretion), change in weight (increa or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when give immediately postpartum, cholestat jaundice, migraine, rash (allergic), rise in blood pressure in susceptibl individuals, mental depression. Although the following side effects have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation posttreatment, premen struallike syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, ar itching. The following occurrences have been observed in users of oral contraceptives (a cause and effect relationship has neither been established nor disproved): thrombophlebitis, pulmonary embolism, neuroocular lesions.

The following laboratory tests may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic functio tests, coagulation tests (increase in prothrombin, factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metyrapone test, pregnanediol determination.

norethindrone — an original steroid from

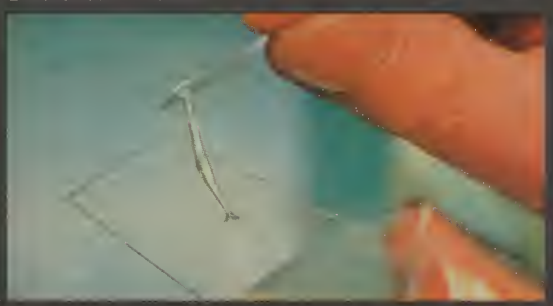
SYNTEX

LABORATORIES INC., PALO ALTO, CALIF.

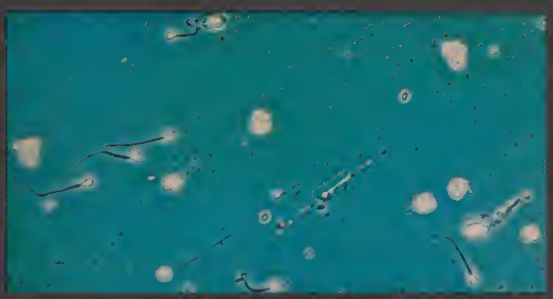
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

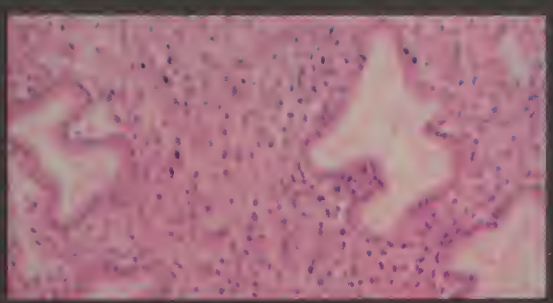
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.



Spermatozoa appear healthy, active, freemoving.

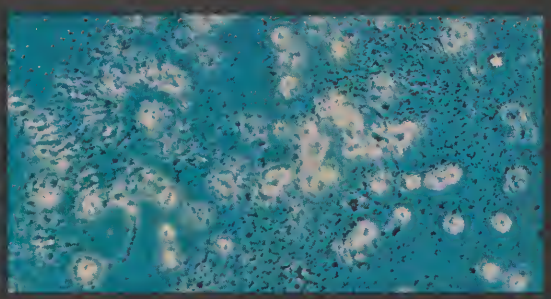


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

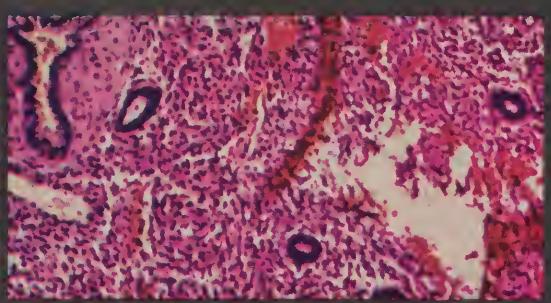
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



Norethindrone in Norinyl-1 accelerates secretory phase, suppresses glandular and vascular development.

Norinyl®-1
(norethindrone 1mg ē mestranol 0.05mg) tablets

- new low dose of time-proved ingredients
- established norethindrone/mestranol ratio
- lower patient cost

An uncommon steroid for common inflammatory dermatoses

In everyday topical steroid therapy, Synalar produces rapid resolution of inflammation and itching in steroid-responsive dermatoses—and at relatively low cost to the patient.

Advanced molecular design enhances potency

Synalar combines the advantage of earlier corticosteroid compounds with unique structural innovations. As a result, preparations of Synalar 0.01% and Synalar 0.025% have been reported to be more potent topically and significantly more effective than hydrocortisone 1.0%. The unique fluocinolone acetonide molecule provides one of the most useful topical corticosteroids for everyday practice.

Impressive clinical results in a wide range of dermatologic problems

The clinical efficacy of Synalar has been extensively documented in the world literature. Commonly encountered diseases such as allergic and contact dermatitis, eczematous and seborrheic dermatitis, and neurodermatitis respond rapidly to Synalar, often where previous therapy with other topical corticosteroids has failed.

Low patient cost for wider usefulness

With Synalar, a high degree of efficacy does not mean high price. And—a small quantity goes a long way. Thus, your patients can often obtain the "economy" of a hydrocortisone preparation with the proved efficacy of a potent, truly advanced steroid.

Synalar®
fluocinolone acetonide





For everyday topical steroid therapy

Synalar® 0.01%

fluocinolone acetonide provides economy in two practical dosage forms

For general use, the most economical and widely applicable concentration of Synalar is 0.01% Cream in a water-washable, vanishing cream base. Synalar Solution 0.01% is especially valuable in dermatoses involving moist, intertriginous areas or hairy sites where creams and ointments do not spread or penetrate readily. Synalar Solution is a unique dosage form—clear, nongreasy, cosmetically elegant.

Product Information

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. *Precautions:* Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. *Side Effects:* Side effects are uncommon with topical corticosteroids As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. In such cases the agent should be discontinued and appropriate measures taken. *Availability:* Synalar (fluocinolone acetonide) Cream 0.025%—5, 15 and 60 Gm. tubes and 425 Gm. jars. Cream 0.01%—15, 45 and 60 Gm. tubes and 120 Gm. jars. Solution 0.01%—20 and 60 cc. plastic squeeze bottles. Ointment 0.025%—15 and 60 Gm. tubes. Neo-Synalar® (neomycin sulfate 0.5% [0.35% neomycin base], fluocinolone acetonide 0.025%) Cream—5, 15 and 60 Gm. tubes.

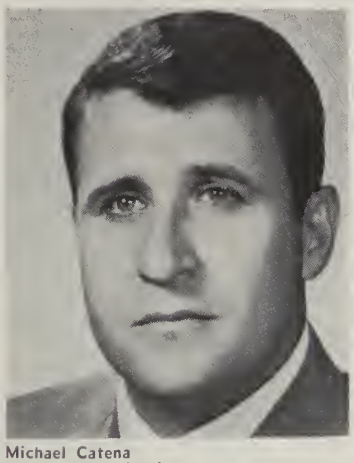
fluocinolone acetonide—an original steroid from

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LABORATORIES INC., PALO ALTO, CALIF.



In Maryland . . .
These Syntex men serve the physician



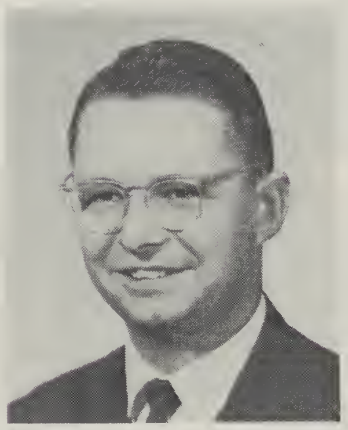
Michael Catena
Library, Pennsylvania
833-4848



Anthony Chirgott
Baltimore, Maryland
488-0742



Wayne Ettare
Falls Church, Virginia
534-3520



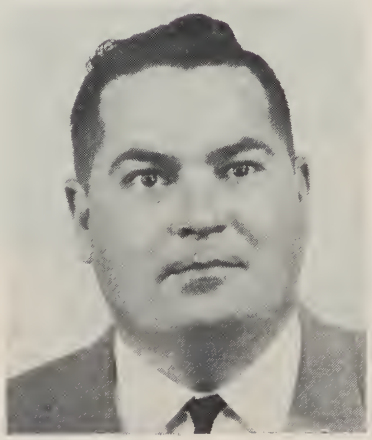
Thomas Grove
Fairfax, Virginia
591-9349



John Mullikin
Queenstown, Maryland
827-8217



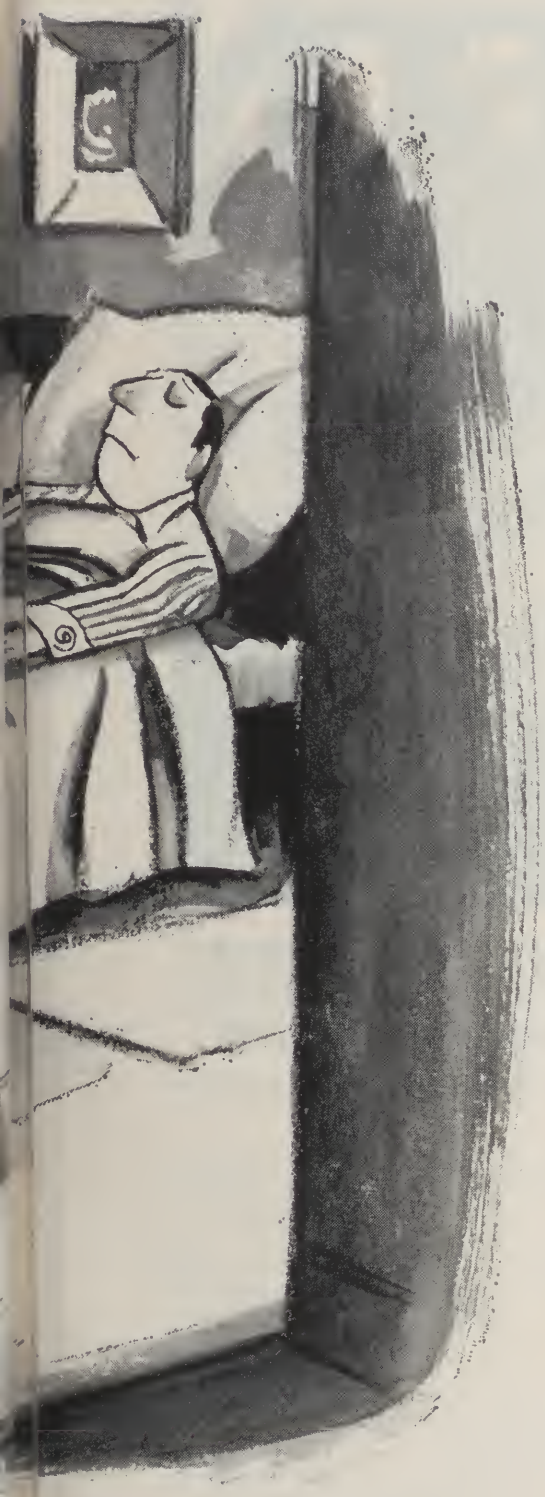
David Mathews
Glen Burnie, Maryland
761-0381



Arnold Felter
Baltimore, Maryland
282-3553



"George wants to know if it's okay to take his cold medicine now, Doctor, instead of seven o'clock?"



The long-continued action of Novahistine LP should help you both get a good night's sleep. Two tablets in the morning and two in the evening will usually provide round-the-clock relief by helping clear congested air passages for freer breathing. Novahistine LP also helps restore normal mucus secretion and ciliary activity—normal physiologic defenses against infection of the respiratory tract. Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result. Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

NOVAHISTINE® LP

DOW **PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis

DEPRESSION



NORPRAMIN®
(desipramine hydrochloride)

ANTIDEPRESSANT FOR RAPID IMPROVEMENT

At the recommended dosage level —initially, 150 mg. per day— gratifying remission of the signs and symptoms of depression typically begins in 2-5 days. Its specificity for depression, rapidity of action and usually mild side effects are significant reasons for prescribing NORPRAMIN (desipramine hydrochloride) in depression of any type . . . any degree of severity.

A few patients, sensitive to central nervous system stimulants may become restless as depression is lifted—in such cases dosage may be reduced or a tranquilizer added.

LAKESIDE

IN BRIEF:

INDICATIONS: In depression of any kind —neurotic and psychotic depressive reactions; manic-depressive or involutional psychotic reactions.

CONTRAINDICATIONS: Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease, epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor.

RELATIVE CONTRAINDICATIONS: (1) Patients with a history of paroxysmal tachycardia. (2) Patients receiving concomitant therapy with thyroid, anticholinergics or sympathomimetics may experience potentiation of effects of these drugs. (3) Safety in pregnancy has not been established.

PRECAUTIONS: (1) Outpatient use of desipramine hydrochloride should not be substituted for hospitalization when risk of suicide or homicide is considered grave. (2) If serious adverse effects occur, reduce dosage or alter treatment. (3) In patients with manic-depressive illness a hypomanic state may be induced. (4) Discontinue drug as soon as possible prior to elective surgery.

ADVERSE EFFECTS: Side effects, usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, anxiety, agitation and stimulation, insomnia, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, tremor, allergy, agranulocytosis, altered liver function, ataxia, and extrapyramidal signs.

DOSAGE: Optimal results are obtained at a dosage of 50 mg., t.i.d. (150 mg./day). **SUPPLIED:** NORPRAMIN (desipramine hydrochloride) tablets of 25 mg.; bottles of 50, 500 and 1000; and tablets of 50 mg., in bottles of 30, 250 and 1000.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

EDITORIAL

The Cogent Reasons

*Joseph H. Hooper, Jr., M.D.**

The *MMPAC* (Maryland Medical Political Action Committee) is rapidly approaching the maturity and sophistication to which it is committed. But why only approaching? Why has it not reached the position of *PAC*s in other states where even the grass root, local political arena has been entered successfully?

The answer is quite clear. Though we have grown dramatically in size we still lack many physician-wife combinations who by their political philosophy should be members.

Why?

Where are they?

We intend to find out.

Should it be possible they have never heard of us, we shall be heard. Should they no longer care, we shall give them reason to care—if not for themselves, then for the future of medicine and future physicians and *most important of all* for patient care, both present and future. After all, our offsprings will live in this world we leave them.

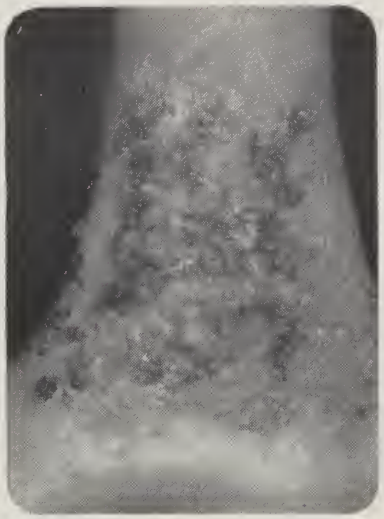
November of 1966 has come and gone and the political friends of medicine have realized more than ever the importance of that friendship. Two re-elected, incumbent Congressmen well realized the help of *MMPAC,* both vocal and financial. One freshman Congressman realised *MMPAC* contributed much toward his assumption of a Washington office. Another freshman incumbent of rubber-stamp-thinking saw himself almost unseated by a strong *MMPAC* supported challenger, in his first attempt at re-election.

This is part of the political picture over the Nation. Why then do physicians hold back? Why can they fail to realize their political potential—their full potential—when acting in an organized, orderly, legal and, if you will, patriotic fashion simply by exercising their God-given right to express their views both at home and, if necessary, at work.

The intent, purpose and activity of *MMPAC* will always be devoted to the full support of the highest professional ideals and those who share in such ideals whether he be physician or politician.

*Chairman, Executive Committee, Maryland Medical Political Action Committee.

Eczema of many years... controlled in two weeks



Before treatment



After treatment—
with ARISTOCORT Topical
Ointment 0.1% for two weeks

ARISTOCORT® Triamcinolone Acetonide Topicals have proved exceptionally effective in the control of various forms of eczema: allergic, atopic, nummular, psoriatic, and mycotic.

In most cases responsive to topical ARISTOCORT, the 0.1% concentration is sufficiently potent. The 0.5% concentration provides enhanced topical activity for patients requiring additional potency for proper relief.

Administration and Dosage: Apply sparingly to the affected area 3 or 4 times daily. Some cases of psoriasis may be more effectively treated if the 0.1% Cream or Ointment is applied under an occlusive dressing.

Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

Available in 5 Gm. and 15 Gm. tubes and ½ lb. jars.

PHOTOGRAPHS COURTESY OF M. M. NIERMAN, M.D.

Aristocort® Topical Ointment 0.1% and Cream 0.1%, 0.5%
Triamcinolone Acetonide
Also available in foam form.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

406-6

Maryland State Medical Journal
Volume 16, No. 11
November, 1967

THE CHANGING ROLE OF THE FAMILY PHYSICIAN IN THE TREATMENT OF PATIENTS WITH CHRONIC RENAL FAILURE

JOSEPH H. HOLMES, MD, D.Med.Sc.
Department of Medicine
University of Colorado Medical Center
Denver

Recent developments in the use of chronic dialysis and renal transplantation for the treatment of patients with chronic renal failure and uremia pose many new problems for the family physician and alter considerably the role he must play in the management of patients with progressive renal failure. The family physician can be an important factor in developing a successful therapeutic program for the patient even though many of the specialized techniques will be carried out in the renal "Center." Many of these advances in the treatment of chronic renal failure have been associated with wide publicity. Therefore, patients and their families are making certain demands for treatment and are groping for answers to many different questions. Since all of these patients first see the family physician, the initial evaluation becomes his problem, as is the decision as to when referral to the "Center" is necessary. The family physician must make the decision as to when the patient should be told about these new treatments. Furthermore, he must explain the problems the patient will face during such treatment, and the approximate chances for success. After the treatment has been initiated at the "Center," the care of the patient when he returns to his own community must rest with the family physician.

At the present time the initial work-up of the patient with renal disease becomes of increasing importance. This work-up should include a determination of the etiology and activity of the renal lesion, evaluation of present status of renal function and evaluation of co-existing medical problems. There should be a consideration of potential related donors, a careful review of all family members for evidence of kidney disease, and a review of the patient and family background in relation to such matters as satisfactory living conditions, cohesiveness of the family unit, religious or moral scruples, patient's occupation, attitude of employer, and the need for job rehabilitation if specific treatment such as transplant or dialysis is initiated. Many of the family and occupational problems which would preclude a successful renal transplantation will influence also the course of a chronic dialysis program.

Perhaps we should review briefly the current problems in renal transplantation, particularly those which must be considered during the initial work-up of donor and recipient.[1] The problems complicating a successful renal transplantation are primarily immunological. There are several important factors to be considered in achieving successful renal transplantation and preventing rejection of the donor kidney. The first is selection of a donor kidney which is most compatible for the recipient. A second factor is the maintenance of the donor kidney during the operative procedure so that it suffers only minimal damage from anoxia and fluid balance changes. A third factor relates to the technical aspects of transplantation in achieving a satisfactory circulatory anastomosis and a satisfactory urinary drainage. A fourth factor is the necessity of using drugs and X-ray to suppress rejection. Those immunosuppressive procedures should be selected which

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are least toxic to the individual recipient and also permit him to achieve maximal body response to any form of stress.

What are the medical criteria which make a patient acceptable for renal transplantation at the present time? The first requisite is selection of a suitable donor. In our transplant program the results with live related donors are much better than with cadaveric organs. In donor selection, major blood group compatibility is a necessity. An O donor may be used for either an A or B recipient and an AB recipient may receive a kidney from any donor. Lymphocytic matching techniques such as those of Terasaki appear to be of real value and at present at our unit a definite mismatch will rule out that donor. However, there is some factor especially in related donors that cannot be currently evaluated by these techniques, so that an occasional good transplant may result even though there is a mismatch with the Terasaki technique.[2] Since the incidence of post transplant complications increases with age of the recipient, we have arbitrarily limited transplantation to those under 41, though exceptions may be made after extensive medical evaluation. The recipient should have no systemic disease such as lupus erythematosis, periarteritis nodosa or diabetes mellitus, nor medical problems such as cancer or tuberculosis which might limit overall prognosis or increase the difficulty of medical management during renal transplantation. The use of drugs to prevent rejection may produce toxic effects so that the recipient must meet certain medical criteria. For example, liver disease should be ruled out since most drug therapy used to prevent rejection may be hepato-toxic. When immunosuppressive drugs are used any infection in the body may flare up and cause death; thus, the detection and elimination of infection prior to transplantation is essential. When steroids are to be used for therapy the presence of a peptic ulcer, diabetes mellitus, or serious bone disease may either eliminate the patient from consideration for transplantation or may require appropriate therapy prior to transplant.

Medical conditions which pose technical problems may also eliminate the patient from consideration for transplant. Ureteral or urethral obstruction or cystitis may either be a contraindication to transplantation or require corrective surgery prior to transplantation. The presence of severe arterial disease in the pelvic region which would make arterial and venous anastomoses difficult may eliminate the patient for transplantation. In addition, a patient may be rejected for transplantation if he has had recent pelvic or intra-abdominal infection. For example, we have had to postpone renal transplantation for several months in patients who had severe peritonitis following peritoneal dialysis.

Finally, the family must be willing to make plans for a period of pretreatment of 5 to 6 weeks and post transplant treatment of up to 3 or 4 months in the immediate vicinity of the "Center." If the dislocation of the family for that period would cause serious problems, then perhaps a reestablishment of residence in the area of the "Center" must be considered. Often early psychiatric and psychological evaluation are necessary for recognition and treatment of those emotional problems which might interfere with post transplant care. With either treatment program there will be a definite period of imposed limitations on employment; thus, the patient's occupation essentiality and his relationship to his employer should be reviewed. Job essentiality means the patient has skills not generally available in the labor market as, for example, a rocket designer, so the employer will make many concessions to retain his services. If the employer is uncooperative, it may be necessary to make a job change or to initiate a job rehabilitation program. In some instances the patient has been eliminated from the transplantation program when emotional problems were uncorrectable, mental retardation was present, or when family or rehabilitation problems were insoluble.

These contraindications to renal transplantation serve as guidelines to the family physician for his initial work-up. Determination of the etiology is of primary importance in ruling out those forms of renal disease not considered suitable at present for renal transplantation. The complete medical evaluation is essential since early treatment of problems like peptic ulcer or infections will transfer the patient to a category acceptable for a transplant program. The same would be true for the psychiatric therapy. The evaluation of renal disease in the rest of the family may lead to therapeutic measures, which will make the pros-

pective donor a suitable candidate. If there are definite contraindications to renal transplantation, the family should be told quite early.

The evaluation of renal function is important not only in prescribing therapy but also in estimating the probable time when the patient may require either chronic dialysis or renal transplantation. This work-up should rule out urinary tract infection and make plans for treating any abnormality of the genito-urinary tract which can be corrected surgically. An intravenous pyelogram, isotopic studies, aortogram, or ultrasonic examination[3] may be valuable in indicating structural abnormalities and in demonstrating residual urine without catheterization. The laboratory studies should include an evaluation of current protein loss, good sediment examinations to assess degree of activity of the renal lesion, renal biopsy if that is necessary to establish either etiology or degree of activity of the renal lesion and a determination of 24-hour urinary excretion patterns for determination of volume, urea nitrogen and electrolyte excretion and creatinine clearance.[6] Since nitrogen retention usually does not occur until the creatinine clearance drops below 25 cc per minute, this has been one of our more effective tests in establishing prognosis. Furthermore, when the creatinine is between 10 and 25 cc per minute the patient will respond well to conservative management. The normal clearance range is 110-130 cc per minute. On a regular hospital diet, urinary urea nitrogen excretion averages 6 gm per 24 hours.[6] Thus, if the patient's daily urea nitrogen excretion exceeds this value, only a moderation in protein intake will be necessary, but if it is below this value dietary protein restriction is required. In renal failure sodium concentration in the urine averages 70 mEq/L even when serum concentrations are reduced. Thus, to prevent hyponatremia in renal failure patients the 24-hour sodium loss must be measured and the diet prescribed to replace this loss (average 4-6 gm NaCl/day). Assessment of the hypertension and the rate of red cell formation are important in planning conservative management and in estimating prognosis. A repetition of the laboratory tests at 3-month intervals will establish the relative progress of the renal lesion and may be important indices for planning rehabilitation or job relocation.

Let us now consider the role of the renal "Center." It may have an assisting function in the evaluation of the patient and particularly in supplying special diagnostic techniques, such as X-ray, biopsy, isotopic studies or ultrasound. The "Center" may also give advice on appropriate therapeutic regimens and discuss with the physician any special problems which they encounter during the initial work-up. When uremia progresses rapidly, the artificial kidney must be considered for therapy.[4] Other indications for dialysis may include the appearance of peripheral neuropathy, pericarditis, inability to work or a sudden change in mental status.

It is well to realize the dialysis load a "Center" faces at the present time since it must support a number of different programs. Table 1 presents the number of dialyses our "Center" performed last year and the number in each type of program. This is in contrast to a dialysis load of 360 in 1963. This type of load taxed our facilities and in some instances patients were turned away. The number of dialyses required for patients awaiting transplantation could be cut substantially with the help of the family physician since in most instances a delay in renal transplantation is directly related to the adequacy of the medical work-up of both donor and recipient.

TABLE 1

Category	Dialyses No.	Patients No.
Acute renal failure	67	23
Chronic renal failure	35	17
Poisonings	15	12
Chronic dialysis	1620	36
Pre-transplant	148	39
Post-transplant	69	13
TOTAL	1954	140

Shows dialysis load and its distribution for 1966 at the University of Colorado Medical Center.

Donor work-up is primarily the responsibility of the family physician and entails complete evaluation of renal function including creatinine clearances, urine culture, adequate sediment examinations, intravenous pyelogram, and aortogram. Blood is also drawn for lymphocytic matching. We feel that careful screening of the donor has eliminated many potential tragedies for both donor and recipient. The donor must have normal renal function and a single renal artery to

the kidney selected for transplantation. The latter is demonstrated by an aortogram. Allergic problems in the donor are usually not a contraindication for proceeding with transplantation. It is important to explain to each donor what being a kidney donor entails, and in the case of family members to make sure that there is proper motivation and no extreme family pressure. Occasionally it helps to have a donor discuss the problem with a psychiatrist from the "Center." Following nephrectomy in the donor, there is a prompt increase in renal function (within 3 days) up to 80% of the control values.[5] In our donor group, the post operative complications have not been serious, limited largely to infections or delayed wound healing.

After the initial renal work-up the patient is placed on good conservative management as dictated by this work-up. The rationale of conservative management in chronic renal disease is to balance the patient's intake of protein, salt and fluid to equal his excretory ability. The determination of the 24-hour excretion pattern will establish the patient's excretory ability under various fluid loads. The proper fluid load is achieved by having the patient weigh daily and increasing the fluid intake as long as the weight remains constant. If a further increase in fluid intake does not increase the urea nitrogen excretion, then there is no reason for establishing the patient's maximum ability to excrete urine. If the patient weighs daily and brings his weight record on each visit to the physician usually the complications of fluid overloading and pulmonary edema can be prevented. Other therapeutic problems in conservative management include the anemia and hypertension. In treating the hypertension, conventional drugs are used with careful observation to be sure that lowering of the blood pressure does not reduce renal function (creatinine clearance). Usually the anemia stabilizes at a hematocrit level of about 25%, and in such cases no further transfusions are required. When it gradually drops below this value, then packed red cells can be given.

The family physician must determine when referral to the "Center" for further evaluation or dialysis is necessary. In a significant group of patients by judicious use of occasional dialysis it is possible to prolong life significantly on conservative management. This is particularly important at present since both transplantation and dialysis are improving rapidly as more effective therapies. On the other hand the patient's conservative management cannot be prolonged until his condition deteriorates so that no further treatment can possibly be successful. The importance of proper time for referral is emphasized by a recent review of 135 uremic patients referred to this "Center." (Table 2)[4] Approximately 42% were referred in such severe uremia that they died within one month, either of the uremia or of associated medical complications, and thus could never even be considered for such programs as chronic dialysis or renal transplantation. For the remaining 58% of these patients, Table 2 shows the relative

TABLE 2

Patients No.	Survival Mos.	Age Yrs.	BUN mg%	Creat. mg%	Output ml
57	–1	42	206	18	804
49	1–3	35	211	17	934
15	3–6	41	210	16	1921
14	6+	46	170	11	2593
135 TOTAL					

Shows rate of survival in months of 135 patients admitted in severe uremia and who received 1–3 dialyses during the initial admission. They are grouped according to length of life after admission and compared with respect to average age, average admission blood urea nitrogen and serum creatinine levels, and average urinary output.

time period after the initial one or two dialyses before they returned to the hospital for further therapy. Fourteen patients improved sufficiently after one or two dialyses to remain at home in good condition for periods of over six months and in one instance up to 7 years.

The results of renal transplantation are difficult to evaluate because of changing techniques and increasing technical skills. The first transplant done at this institution was in November 1962, using body radiation for suppressing rejection. In subsequent transplants azothioprine and steroids constituted the primary immunosuppressive therapy. Since August of 1966 we have been using antilymphocytic globulin which appears to suppress particularly the early rejection phenomenon observed previously. This serum is prepared by injecting human spleen, lymph nodes and thymus

into horses. The titer is determined by leucocytic agglutination tests and a daily dose of approximately 1000 units/Kg given intramuscularly.[7] No serious reactions have occurred except for the extreme pain associated with the injections.

The results of transplantation at this institution (excluding the antilymphocytic globulin group) show that the results are much better if related donors are used when compared with the results using unrelated living or cadaveric donors. This is illustrated in Table 3. In fact, unrelated living donors probably should not be used at the present time. Results seem to be better when the lymphocytic matching indicates a good match between donor and recipient. In a few cases the first transplanted kidney has been rejected and a second transplant done. In these patients it is too early to determine whether the second transplant will be successful. Some patients were supported by dialysis for several months prior to receiving their second transplant, and in these patients dialysis has been most difficult because of the associated infections and general debilitation.

TABLE 3

Donor	Group 1—75 kidneys		Group 2—64 kidneys	
	Survival %	Duration Mos.	Survival %	Duration Mos.
Fraternal twin	50	40	—	—
Mother	59	32–44	64	1–12
Father	80	28–32	80	11–18
Sibling	44	28–42	83	1–22
Living unrelated	14	28–34	45	9–21
Cadaver	0		56	4– 8

Shows homografted kidney survival rate in 139 kidneys transplanted at the University of Colorado Medical Center from November 1962 to September 1966. Group 1 (November 1962 to April 1964) represents the transplants prior to Terasaki matching and Group 2 (October 1964 to September 1966) represents donors selected by Terasaki matching. Immunosuppressive therapy was primarily azothioprine and prednisone, and this Table represents results prior to use of antilymphocytic globulin. (Prepared March 1967)

A recent editorial has summarized very well the causes of post transplant death.[8] The deaths were arbitrarily divided into early death (first 24 days) and late death. Causes of early death were related primarily to technical failures, to post operative surgical complications or to medical complications unrecognized prior to transplant. Only 25% of the deaths were due to sepsis. (Table 4) In contrast, in the late deaths over 75% were caused by sepsis

TABLE 4

Cause of Death	Patients No.
Pulmonary embolism and/or infarct	5
Sepsis	4
Renal Failure	2
Myocardial infarct	1
Congestive heart failure	1
Electrolyte imbalance	1
Hemorrhage	1
Ruptured spleen	1
TOTAL	16

Shows the primary causes of early death (0 to 24 days) in 118 organ transplants from March 1962 to December 1965.

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and only 10% were due to renal failure. (Table 5) The type of organisms causing death were a rather unusual group as shown in Table 6. Many of these organisms are not usually considered pathogenic in other medical situations. The relation of deaths due to renal failure and those due

TABLE 5

Cause of Death	Patients No.
Sepsis	38
Renal failure	5
Hepatitis	1
Hemorrhage	1
Pulmonary emboli	1
Congestive heart failure	1
Pancreatitis	1
Unknown	1
TOTAL	49+

+5 patients were assigned 2 causes of death

Primary causes of late death (more than 24 days after surgery) following organ transplantation in 123 patients during period November 1962 to December 1965.

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TABLE 6

Organism	Cause of Death No.
Pseudomonas	15
Paracolon, Klebsiella, E. coli	7
Staphylococcus, pneumococcus	3
Nocardia	3
Aspergillus	7
Candida	9
Histoplasma	1
Pneumocystis	2
Hepatitis	1
TOTAL	48

Shows type of organisms recovered at autopsy in 48 patients who died in the post-transplant period and in whom this infection was considered the primary cause of death.

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to infection depends on the approach adopted by the transplant physician. The more extensive use of immunosuppressive agents will often prevent rejection but subject the patient to a greater chance of lethal infection, whereas minimal use of immunosuppressive drugs will result in a greater incidence of rejections. I would like to emphasize these late complications of transplantation because it is important that the family physician be aware of these problems so that he can detect them early and refer the patient to the "Center" for more specific therapy. Many of these infections occur after the patient has returned to his home.

We are currently at a phase of treatment of chronic renal failure either by chronic dialysis or by transplant where both techniques require further investigation and development. In some patients we do achieve good results and since no other therapy is available, undue pressures are exerted by the community to treat all patients. However, since the facilities of dialysis and transplant units are limited, there is still the unfortunate situation that certain patients must be refused treatment. There are probably some patients who should not be advised to go through with either type of therapy at the present time. The patient himself must have a strong desire to live and be willing to start a new life. The request for treatment must be a result of the patient's desires and not family pressures. Furthermore, since the treatment itself is going to inconvenience the family for many months, will they be willing to make the necessary sacrifices? These are some of the problems that must be considered when a patient is referred for either renal transplantation or chronic dialysis.

The treatment of post transplant complications has severely limited the number of beds available for new patients in any transplant program. Thus, it would seem that at the present time when transplant is considered as a method of therapy, selection of ideal patients is justified. Whenever a patient has certain medical problems which we know will complicate transplantation, perhaps the patient should be deferred for the transplant program until our methods and techniques improve. Furthermore, if we are to develop these techniques to maximum effectiveness, there must be some degree of patient selection along the lines of trying to find out what we need to know to improve current techniques. Thus, the acceptance of a patient for renal transplantation represents a judgment based on medical evaluation and availability of facilities.

Following transplantation the patient usually lives near the "Center" for a period of several months. When the patient and his family return to his home, the role of the family physician becomes a very important one, both in helping the patient adjust to a new life and in detecting medical complications early so that they can be treated effectively. Medical evaluation must be directed toward the detection of toxic reactions to immunosuppressive agents, the detection of any change in renal function which might indicate rejection[9] and the detection of infections. At present the family physician must work closely with the renal "Center" group, at least until we have a better understanding of the possible complications associated with renal transplantation. Whenever close working relations are established with the family physician, life expectancy is greater than when a patient is returned to his home and the liaison between the "Center" and the family physician is inadequate.

The choice by the family physician of a proper medical program for the patient with chronic uremia is not a simple one. The physician is beset by family pressures generated by premature publicity. He must decide before referring a patient to

a renal "Center" that this patient represents a candidate in whom there are definite reasons to suggest that transplant or chronic dialysis will yield good therapeutic results. Furthermore, the referral must be made at the proper time and a good medical work-up provided the "Center" at the time of referral.

Summary. The improvement in renal transplant and chronic dialysis techniques, together with current publicity, has brought undue pressures on the medical profession to treat all patients with chronic renal failure. The family physician must assume a new role in the treatment of patients with chronic renal failure. The effectiveness of his initial work-up and his medical management of the patient may often be the determining factors in whether results with either chronic dialysis or renal transplantation will be successful. He must work closely with his associated renal "Center," both in the pre-transplant and the post-transplant periods. Furthermore, with currently limited facilities he can best determine the most suitable candidates for either program. Whenever after initiation of one of these programs the patient is returned to his own community, then the family physician is responsible for helping the patient readjust and for continued medical evaluation and care. Furthermore, close liaison with the renal "Center" is essential both for care of the patient and for obtaining more complete information which is necessary to improve our treatment programs.

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NEW DIMENSIONS OF HEALTH PLANNING

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In doing some homework for this Michael Davis Lecture, I undertook a rapid re-reading of Dr. Davis' book *Medical Care for Tomorrow,* published in 1955. It was not a very successful job of skimming, for the book is difficult to skim—largely because each paragraph is packed with information and ideas that are very much alive today. In the process I acquired, or reacquired, a great many useful concepts.

But I was interested also in something I did *not* find in Dr. Davis' book. Unless I missed it somewhere, I found no discussion of health planning as such, in anything resembling the context and terminology we are hearing everywhere today.

This omission reflects no criticism on Dr. Davis. As all of us know, his mind has been ranging far out in front of most of us for nearly half a century. The point I am seeking to make is that *even* Dr. Davis didn't write about health planning twelve years ago, because this concept had not yet appeared over our horizon. It is a very new idea. Max Ways calls it a "new style in problem-solving."

Because it is new, and widely discussed, and generating a great deal of heat and confusion, I thought that this new style in health planning would be an appropriate topic for my Michael Davis Lecture. I don't promise instant clarification. But I do believe that in this new style lies our best hope of meeting unlimited aspirations with limited resources.

The Michael M. Davis Lecture, University of Chicago, May 25, 1967, Chicago, Ill.

For that is the heart of the contemporary dilemma in health and medicine. Public expectations for health care have been immeasurably heightened by the advance of biomedical capability, public awareness of that advance, and simultaneous social changes that have rejected for all time the notion of privilege. Access to good health care, like access to education, has been accepted as a right, for everybody.

Meanwhile, resources available for health have been growing, too—in terms of manpower, facilities, and plain money. Well over 40 billion dollars were spent for health purposes in the United States last year. This represents an impressive 6% of our Gross National Product as compared with less than 4% when Dr. Davis published his book. Yet even this growth has not kept pace with public expectation.

Therefore the answer to the question, "Why plan?", is simple and clean. Whenever desires exceed resources, choices must be made. If they are to be made intelligently and productively, they must be based on an intelligent assessment of alternatives. Planning is the process of serving up alternative courses of action and their foreseeable results.

At this point let me offer my first word of warning. Planning is *not* a decision-making process. Rather, it is a process of projecting and documenting alternatives. The choices are made through the political and social decision-making

processes of society. Ultimately they are made by the people themselves.

Along about here in any discussion of planning, a troublesome question arises in the minds of the professionals who have been on the firing-line a long time. "Why all the fuss about planning? Haven't we been planning for years?"

The answer is both yes and no. If by planning we mean a process of distributing a given quantity of resources among a given number of programs, year by year, then planning is what most administrators do, most of the time. Given a certain number of bricks and a certain quantity of mortar, it is fairly easy to determine how many buildings can be put up and how large the buildings can be.

A certain amount of this tactical, hand-to-mouth planning always needs to be done. But unless a great many dimensions are added to it, the results over a period of years are likely to become less and less responsive to the real needs. We tend to multiply the same old structures, year after year. We tend to count the growing number of structures and measure progress by it. Vested interests develop, based on refined expertise in constructing the same things. Budget requests and allocations are cast in the comfortable, conventional terms. Voices crying that maybe we should use lumber instead of bricks, or make different kinds of buildings, or possibly not construct buildings at all, are increasingly ignored.

This is an oversimplified metaphor. But something like it has happened in health, in education, in welfare, in armaments, in theology—at one time or another it has happened in virtually every field of human endeavor. The new style of planning and problem-solving is designed to substitute a more effective process for the traditional muddling-through.

Consider, for example, a problem familiar to all of us—providing health care for the children of America. The traditional approach to planning would call for an effort to train increasing numbers of pediatricians and supporting personnel, establish increasing numbers of child health clinics, carry out larger immunization campaigns, and so on. The product of these programs would constitute the quantitative measurement of progress. Each of these separate lines of attack would have its vocal champions, and they would be vigorously competitive for the lion's share of the resources devoted to the health of children.

The new style of planning would approach the problem quite differently.

It would begin with a definition of goals. How healthy do we want our children to be? Do we mean all children or just those for whom private pediatric care is readily accessible? Are we interested only in mortality, or do we care about morbidity as well?

The next step, growing out of the first, would be the refinement of these broad goals, insofar as possible, into measurable terms. What level of infant mortality are we shooting at? What is an attainable objective over a given period of time for mortality rates in childhood, in adolescence? How low can we expect to bring the incidence of communicable diseases, of chronic diseases, of accidental injuries?

Then comes a stage of intensive input of information. How many children will we be dealing with in 1975, according to best present estimates? What will be their pattern of sickness and health if current trends persist unchanged? Where and in what circumstances will those children live? How many of today's children are being served by today's pediatricians and clinics, and how many of tomorrow's children will tomorrow's resources be capable of serving?

Now we need to project our objectives against the information we have gathered. What does it take to get there from here? Will a major effort to develop "more of the same" do the job? If not, what shifts in priority or emphasis give promise of carrying us farther toward our child health goals. Should we be training an entirely new breed of health worker? Should we be experimenting with new systems of delivery of care that conform to none of the traditional patterns?

Finally, we need to consider how this child health effort relates to the larger world of health programming, and to the still larger world of national resource investment. How much can we ask the nation—or the State, or the city—to invest in child health services in relation to the investment in care of the aging, in biomedical research, in housing, in transportation? What are the trade-offs, and what are the pay-offs?

Obviously this is an immensely complicated process. Also obviously, I have hit only the high spots and have skimmed with a brief phrase a

number of procedures that may require an exhaustive exercise in data gathering and projection. Looking at the enormity of the task, I think it is perfectly fair to ask the question that many are in fact asking these days: Is the game worth the candle?

I am convinced that it is. In fact I am convinced that we in the health business have no alternative but to learn the rules and play the game to the hilt.

We have no alternative because health is too big a business—a $43 billion business; it is too high on our society's list of priorities; it is too close to the heart of society's highest goal—the fulfillment of the individual. We could get by with our old hit-or-miss methods in the days when medical science was a pill and a prayer, and when health care was tacitly assumed to be a privilege for the rich and a pacifier for the poor. But no longer. Not when access to the best in health care is the expectation of every American and that expectation is too often unfulfilled.

Let me return now to the process I described a moment ago. The product of that process is not a master plan or blueprint for the future. But—as I suggested earlier—a set of alternatives. It places before the decision-makers a set of means to achieve objectives leading to a broad social goal. Insofar as possible it indicates the amount and kind of investments required—in terms of money, manpower or other resources—to accomplish certain ends. The system says, in effect: "So much input here can be expected to produce so much output there. On the other hand, if you choose this alternate mix of priorities, you should get this other result." Sometimes they are administrators; sometimes they are politically responsible officials; sometimes—always, in the long run—the decision-maker is society itself. The identity of the decision-maker depends upon the nature and level of decision required. But the planning process never makes the choice.

Moreover, these decisions we are talking about are not made once and for all time. The process is continuous. New information is constantly being fed into the system. New assessments of objectives are constantly being made as the terms of the total equation change. In our field of health, for example, a sudden advance in knowledge and technology may cause a complete re-shuffling of the deck of priorities and methods. Or success in attaining one objective may lead to the creation of new problems requiring high priority attention. If the planning process is working well it is sensitive to the shifting winds that should lead to modifications in operation.

Having followed the planning process through to its point of presenting alternative courses, and having identified the decision-makers, we need to discuss one rather important additional matter. Someone has to implement the decisions.

In the United States we have evolved a health services system which is really not a system at all. It is rooted in pluralism and individualism. Its basic elements are the private practitioner, the community hospital, the health department, the voluntary agency, the educational and research institution, and—sometimes forgotten but very important indeed—the consumer of services. No mechanism exists, nor is such a mechanism contemplated, that will dictate what each or any of these components shall do at any given moment. We sometimes talk about *mobilizing our health resources* but we are using a very loose figure of speech. Our health resources are not an army, conditioned to respond when someone pushes a button, but a proudly and fiercely individualistic group of elements linked only by their common commitment to health.

Therefore, implementation of even the best-laid plans is voluntary. In most cases it is sporadic and uneven. But two elements of the planning process can help to make this voluntary implementation work. One is the success and skill with which the alternatives are developed and documented. The other is the breadth of participation in the planning process itself.

People and institutions dedicated to health goals will—as they have demonstrated many times—act promptly and effectively if they are convinced that the proposed action is best calculated to advance the nation's health. And people and institutions dedicated to any goal will participate vigorously in a course of action that they have helped to shape.

Max Ways, to whom I have already referred, presented a useful six-point summary of some of the characteristics of this new planning process in an article in *Fortune Magazine* this past January:

1. A more open and deliberate attention to the selection of ends toward which planned

action is directed, and an effort to improve planning by sharpening the definition of ends.

2. A more systematic advance comparison of means by criteria derived from the ends selected.
3. A more candid and effective assessment of results, usually including a system of keeping track of progress toward interim goals. Along with this goes a "market-like" sensitivity to changing values and evolving ends.
4. An effort, often intellectually strenuous, to mobilize science and other specialized knowledge into a flexible framework of information and decision so that specific responsibilities can be assigned to the points of greatest competence.
5. An emphasis on information, prediction, and persuasion, rather than on coercive or authoritarian power, as the main agents of coordinating the separate elements of an effort.
6. An increased capability of predicting the combined effect of several lines of simultaneous action on one another; this can modify policy so as to reduce unwanted consequences or it can generate other lines of action to correct or compensate for such predicted consequences.

To these six I would add two more, although both are implicit to a certain extent in a couple of Mr. Ways' points.

The first is that the planning process should have the broadest possible base of input, representing not only the private individuals and public and private institutions involved in providing health care but also the private individuals and institutions involved in receiving it, and in relating health to other activities of society. This breadth of participation has two vitally important virtues: it improves the planning, and it enhances the likelihood of implementation.

My second point is that planning should be done and decisions made where the problems are—as close to the people as possible. National planning is important and necessary, but it must indulge in generalities of uneven application across the nation. Regional planning and State planning are better able to establish meaningful priorities and produce workable sets of alternative actions. Local planning is most relevant of all for the practical application of resources to the solution of genuine problems.

These two principles, in conjunction with the broad concept of planning outlined by Mr. Ways, underlie the two major experiments now underway for which the Public Health Service has responsibility—the comprehensive health planning program under P.L. 89-749, and the regional medical programs authorized by P.L. 89-239.

I submit, therefore, that planning in the new style is rich in promise for health. I believe it can help relate our fragmented efforts to each other, and relate our total efforts to the broader currents of society. I do not envision it as a great white magic, but as a useful way of getting the most health for our very large investment.

I am aware as a physician that no one should prescribe a new course of therapy without taking into account its possible harmful side effects. There are hazards involved, some of which can be inferred as the converse of the principles I have outlined.

One hazard—the one which has caused many to fear the word "planning" for many years—is the idea of one master-plan or blueprint superimposed on the nation from above. No such master-plan exists, nor is it likely to exist, nor does the means exist for superimposing it. Rather the tide is running strongly the other way—toward local determination.

Another danger, more real and present than the first, is the danger of rigidity. Regardless of where planning is done, it is possible that a course of action, once chosen, will tend to be fixed for eternity. To be successful, planning must be ever sensitive to change and decision-making ever flexible.

A third hazard is that planning may become an end in itself, rather than a means to an end. New techniques and methodologies can generate a kind of cultism that seeks to force problems into a preconceived mechanism, instead of continually adjusting the means to the ends.

Fourth, as I have already stressed, there is the danger that planning can become divorced from those who must carry out the action and those who are affected by it. There is a world of difference between "planning for" and "planning of and by" the people.

And one final word for those of you who, like myself, occasionally have the uneasy feeling that something of warmth and humanity might go out of the world of health as the emphasis on planning comes in. William Gorham, who was one of Secretary McNamara's assistants in the Department of Defense when some of the new planning techniques were being pioneered and who is now an Assistant Secretary of Health, Education, and Welfare, had this to say in a recent talk:

"It must be obvious that economic criteria are not the only criteria which should be applied to the allocation of resources and the distribution of program outputs. Nor do the analyses made . . . constitute a pre-packaged *Instant Decision* dents at a liberal arts college, and then continsense, and compassion or turn resource allocation decisions over to computers."

There is still room for judgment, common sense and compassion. In fact they are as indispensable as ever. The new style, the new techniques, seek to give judgment and common sense a firmer base in truth and a clearer look at consequences. They seek to open doors so that compassion can reach more people to greater effect. So long as our ultimate goal is the fulfillment of the individual human being, sensible and compassionate human beings remain the ultimate weapon.

Reprint from Regional Medical Program Bulletin, August 17, 1967.

SHARE YOUR MEDICAL JOURNALS WITH COLLEAGUES OVERSEAS

The doctors of the U.S.A. are being asked to send their medical journals—after they have read them—to colleagues overseas (Asia, Latin America, and Africa) who wish to have access to current medical literature but, either because of currency regulations or actual cost involved, cannot themselves subscribe to medical periodicals. We can supply you with the name, address, and medical specialty of doctors in these areas who would be happy to receive these much wanted journals, (*particularly specialty journals*), which you will mail direct to your overseas colleague.

This is a direct "Doctor-to-Doctor" program which is being sponsored by the American Medical Association with the collaboration of The World Medical Association to help alleviate the lack of current medical publications and to further international good will. Your cooperation in this program will be greatly appreciated and your contact with these colleagues in other countries, we can assure you, will prove very gratifying. If you wish to participate in this program, send your name, address, and titles of journals you will contribute to DOCTOR-TO-DOCTOR PROGRAM, Ada Chree Reid, MD, Director c/o The World Medical Association, Inc., 10 Columbus Circle, New York, New York 10019.

THE PHYSICIAN AND THE NATIONAL LIBRARY OF MEDICINE

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National Library of Medicine

Introduction

When the National Library of Medicine was established in 1836 as the Library of the Surgeon General's Office (US Army), the Surgeon General was authorized to spend $150 for medical literature. Today the Library, located at Bethesda, Maryland, near Washington, in a five-story contemporary building which it has occupied since 1962, is regarded as the world's largest in biomedicine. Among its holdings of 1,300,000 items, in seventy languages, are 315,000 monographs; 310,000 bound journal volumes; 285,000 theses; 168,000 pamphlets; and 4,500 reels of microfilm.

The Library provides 175,000 interlibrary loans annually, and of these 160,000 are photocopies of journal articles not available at the requesting local library. Reference personnel answer 10,000 personal inquiries, 10,000 phone inquiries, and 2,000 mail inquiries each year. Requests for 100,000 library items are made by 25,000 to 30,000 persons who use the reading room each year.

The Library is a major publisher of biomedical bibliographies; eg, *Index Medicus, Cumulated Index Medicus, Bibliography of Medical Reviews, Biomedical Serials* 1950-1960, *Bibliography of the History of Medicine;* and *NLM Current Catalog.* Among other Library publications are *Medical Subject Headings,* the thesaurus for *Index Medicus,* List of Journals Indexed in *Index Medicus;* National Library of Medicine Classification; and *Russian Drug Index.*

The National Library of Medicine

Known for 86 years as the Library of the Surgeon General's Office, the Library was developed as both a national and an international resource by John Shaw Billings, MD, Librarian from 1865 to 1895. In 1922, it was renamed the *Army Medical Library* and in 1952 was again renamed, the *Armed Forces Medical Library.* In 1956, under legislation introduced by Senators Lister Hill of Alabama and John F. Kennedy of Massachusetts, it was transferred to the Public Health Service, Department of Health, Education, and Welfare, and named the *National Library of Medicine.*

The Library was established by the Congress of the United States to assist in the advancement of medical and medically related sciences by the collection, dissemination, and exchange of scientific and other information important to the progress of medicine and of public health.

Towards fulfillment of its mission the Library 1, acquires and preserves books, periodicals, films, prints, and other library materials pertinent to medicine; 2, organizes these materials by appropriate cataloging, indexing, and bibliographic listings; 3, publishes and disseminates catalogs, indexes, and bibliographies; 4, distributes materials through interlibrary loans, photographic, or other copying procedures; 5, provides reference and research assistance; and 6, encourages, promotes, and supports activities to further the progress of medicine and of public health by strengthening existing services and developing new ones.

The Congressional mandate was strengthened recently when, on October 22, 1965, President Johnson signed the Medical Library Assistance Act, Public Law 89-291 of the 89th Congress. In signing the Act, the President commented that the

Nation's medical libraries are a vital link between medical education, practice, and research, and that too little attention has been given to the problem of collecting and sharing scientific knowledge.

The Medical Library Assistance Act is an amendment to the legislation authorizing the establishment of the Library. The Act permits assistance to medical libraries for construction and renovation, for acquisition and for improvement of resources, for training of medical librarians and other information specialists, for preparation of publications, for research in medical library science, and for the development of regional medical libraries. The Act also authorizes traineeships, fellowships, and special scientific projects by individuals or institutions.

Administration of the Act on behalf of the Library is done by the Library's Extramural Programs.

The Library today serves as the principal national focus of resources and programs for bettering communication in medicine and the health sciences and is encouraging the development of the existing system of medical libraries into a national medical information network. on July 1, 1967, the Library acquired the Public Health Service Audio-visual Facility in Atlanta, Georgia. This facility renamed the *National Medical Audiovisual Center* will coordinate a national program in biomedical audio-visuals.

Access to the collection is facilitated through an interlibrary loan program. When libraries request loans through medical library channels, the National Library of Medicine lends books within the United States and, worldwide, provides single copies of articles from journals which the requesting libraries do not possess and which are not available locally. There is no charge for this service or for other services except special photography.

The Library collects materials comprehensively in some forty biomedical subject categories and selectively in many related categories. The collection, in which are over 19,000 serial titles, is increased annually by 95,000-100,000 items. It is estimated that the Library now stores 360 million pages, of which 85 million are pre-1870, and that at least 10 million more are being acquired annually.

Its History of Medicine Division alone has between 60,000 and 65,000 printed works bearing publication dates earlier than 1801. Included in the collection are: an Arabic manuscript of the year 1094 on gastrointestinal disease; a collection of palm-leaf manuscripts from Ceylon, in Singhalese; works of Hippocrates and Galen; and letters written by George Washington, by Benjamin Rush, and by Florence Nightingale. Holdings also include 535 incunabula; 33,000 16th, 17th, and 18th century monographs; 1,600 17th century theses and pamphlets; 2,000 early American medical works; and an estimated 60,000 prints and photographs.

Computerized Library Services

Efforts of conscientious, busy practitioners to achieve and to maintain awareness of the most recent medical discoveries and applications have often led to many and continuing frustrations. The increase in the volume of medical literature and in the number of users has not been paralleled by equivalent growth of medical libraries and of information storage and retrieval methods and facilities adequate to catalog, index, store, and retrieve literature for use of physicians, scientists, and others. Therefore, the Library adopted computerization as a means of assisting, supplementing, and complementing traditional approaches to management of published biomedical literature and pioneered in the use of computers for storage and retrieval of bibliographic information.

In January 1964, a computer-based information storage and retrieval system called *MEDLARS* (Medical Literature Analysis and Retrieval System) became operational at the Library.

MEDLARS joins the professional experience of trained literature analysts and searchers with the processing capabilities of a high-speed electronic computer. The literature analysts, using terms selected from a thesaurus of approximately 7,000 terms, *Medical Subject Headings* (Part II of the January issue of *Index Medicus*), characterize each article by assigning to it a number of subject headings or descriptors. Indexed articles are entered into the computer and transferred to magnetic tapes for storage, and for rapid retrieval. Currently, *MEDLARS* contains over 550,000 citations to biomedical journal articles published since January 1964. About 55% of these are in English.

MEDLARS has improved the quality of the

Library's monthly *Index Medicus* and has substantially reduced the time required for the production of other Library bibliographies.

Index Medicus, a comprehensive, monthly subject-author index, now incorporates 180,000 articles annually from nearly 2,300 of the world's biomedical journals. At the close of each calendar year, *MEDLARS* compiles *Cumulated Index Medicus,* a complete listing, with cross-references, of the citations which were printed in that year's issue of *Index Medicus.* An abridged edition of *Index Medicus* for the personal use of physicians is being planned in cooperation with the *AMA.*

(*MEDLARS* does not now include monographs, symposia, conferences, congresses, and proceedings not published in journals.)

The journals indexed in *Index Medicus* (approximately 2,300) are selected with the advice of an extramural committee whose decisions are made largely on the quality of the journal under consideration; however, care is taken to assure subject balance. Discussions of journals are based on prior knowledge of the journal and on inspection of the journal by committee representatives. In addition, the committee is assisted by advice from subject specialists. Comprising the present committee are physicians and scientists, medical editors, and medical librarians.

MEDLARS makes possible rapid machine searches of biomedical journal literature to obtain answers to reference questions that cannot be handled expeditiously by manual searches. Machine searches which provide citations to medical literature in specific areas of interest are called demand bibliographies.

MEDLARS is responding to more than 400 highly specific computer search requests monthly. These requests are coming chiefly from physicians, techers, and researchers in medical schools, hospitals, universities, and Federal research laboratories.

In addition to demand bibliographies, the Library collaborates with professional societies and other professional organizations in the preparation of "recurring bibliographies"—formally published, widely distributed bibliographies in specialized subject areas of broad interest.

These recurring bibliographies are *Artificial Kidney Bibliography; Bibliography of Medical Education; Cerebrovascular Bibliography; Fibrinolysis, Thrombolysis, and Blood Clotting; Index of Rheumatology; Index to Dental Literature;* and *International Nursing Index.*

Although the Library supplies the sponsoring organization with citations retrieved periodically from *MEDLARS* on film ready for offset printing, publishing and distributing the bibliography—on a non-profit basis—are the responsibility of the sponsoring organization.

At frequent intervals, generally monthly, the Library selects from its demand bibliographies a few considered to be of general interest. Announcements of the availability of these bibliographies, called *NLM Literature Searches,* appear in *JAMA, Public Health Reports, Journal of the American Dental Association, NLM News,* and other publications including state journals. There is no charge for these "Searches." Clinicians, educators, and researchers interested in receiving notices on new *NLM Literature Searches* may write to the Office of the Assistant to the Director.

To enhance effectiveness of *MEDLARS,* the Library has provided its computer tapes and programs to university-affiliated centers which can make computer-generated demand bibliographies available locally or regionally to qualified practitioners, educators, and researchers. Decentralized *MEDLARS* stations are now in operation or will soon be in operation at Harvard University, the University of Alabama, the University of California at Los Angeles, the University of Colorado, and the University of Michigan. Others are being considered, and as regional libraries, authorized by the Medical Library Assistance Act, are identified, they, too, will be provided with a *MEDLARS* search capability.

Two *MEDLARS* centers are in operation outside the United States: In the United Kingdom under a cooperative arrangement between the University of Newcastle-upon-Tyne and the National Lending Library for Science and Technology at Boston Spa, Yorkshire, demand bibliographies are provided by the Lending Library. In Sweden, literature references taken from MEDLARS tapes are being provided by the *Karolinska Institutet* in Stockholm.

Physicians wishing to obtain demand bibliographies are encouraged to seek the advice of local medical librarians on suitability of the inquiries and on the preparation of requests which will

elicit the information sought. The use of *Medical Subject Headings, Guide to MEDLARS Services,* and an expression of specific interests will help avoid retrieval of irrelevant citations. Thus, a request specifying animal experiments will help to insure that citations on human studies will not appear in the bibliography; similarly, specifying a single age group will obviate retrieval on all age groups.

Citations may be arranged alphabetically by senior author, by journal title, by language, by subject headings, and by year of publication, and each citation can be printed with the descriptors assigned to it by its indexer. Although the computer can print bibliographies on 8½″ x 11″ paper or on 3″ x 5″ cards, usually the printout is provided on the less costly paper.

The elapsed time between receipt of a request and mailing of a bibliography is a function of the volume of searches requested. At present, elapsed time is about three weeks.

It is important to note that *MEDLARS* does not produce abstracts. It is also important to note that *MEDLARS* services are not provided for searches which can be conveniently and readily accomplished by the use of published indexes, handbooks, and other reference materials.

Demand Bibliography Requests from Maryland

During the period July 1966-June 1967, inclusive, the National Library of Medicine responded to 844 demand bibliography requests from biomedical personnel in the State of Maryland.

Examples of these requests are: Innervation of the Mammalian Ovary, Conceptual Development in Educable Mental Retardates, Lipomas of the Duodenum, Incidence and Surgery of Melanoma in Pregnancy, and Pharmacodynamics of *DNA.*

The distribution of the 844 requests was:

Johns Hopkins University	45
St. Joseph College	1
University of Maryland	20
Federal	727
Other (Chiefly Physicians)	51
Total	844

Summary

The National Library of Medicine, now the world's largest biomedical library, was established by Congress to further the advancement of medical and medically related sciences by the collection, dissemination, and exchange of scientific and other information important to the progress of medicine and of public health. It has become an international as well as a national resource for publications and other items relevant to medical communication, and renders service on a worldwide basis.

In January 1964, a computer-oriented information storage and retrieval system called *MEDLARS* (Medical Literature Analysis and Retrieval System) became operational at the Library. This system has improved the quality of *Index Medicus* and other Library-associated publications and has substantially reduced the time required for preparation and publication of such publications.

The *MEDLARS* store of biomedical journal articles published since January 1964 now exceeds 550,000 and is growing at an annual rate of 180,000 articles, taken from nearly 2,300 journals. Requests for computer searches come chiefly from physicians, teachers, and scientists in medical schools, hospitals, universities, and Federal research laboratories.

During the period July 1966-June 1967, inclusive, the National Library of Medicine responded to 844 demand bibliography requests from biomedical personnel in Maryland.

*National Library of Medicine, 8600 Rockville Pike, Bethesda, Maryland 20014.

END MEASLES MENACE IN MARYLAND MAY, 1967

JOHN H. JANNEY, MD, Chief
Division of Communicable Diseases
Maryland State Department of Health

In 1966, when the Maryland Immunization Project was implemented, measles vaccine had been available commercially for several years. Measles immunization had quickly become a routine practice in well baby care in many physicians' offices and health department clinics. Yet the State Department of Health surveys showed that 50% of the children under five were still susceptible to measles, as well as 34% of the six through fourteen year olds.

Perhaps the seeming familiarity of measles led to mistaken complacency. Many parents, on the centuries old assumption that measles was merely a routine hazard of growing up, had not availed themselves of this effective new vaccine to protect their children.

But to parents who have nursed a sick, feverish baby through measles, this disease is no slight hazard; nor are physicians and public health workers casual about measles. In the autumn of 1966, a nucleus group of concerned parents, physicians, and public health officials felt that more must be done to vaccinate all of the measles susceptible children in Maryland. By October, informal exploratory conversations were being held by State Health Department Immunization Project staff with Karl M. Green, MD, chairman of the Child Welfare Sub-Committee of the Medical and Chirurgical Faculty local health officers, and with representatives of the Maryland Association for Retarded Children, and the State Jaycees.

The End Measles Menace in Maryland campaign grew out of those explorations, and before the end of May, 1967, more than 66,000 children had been vaccinated at nearly 100 clinics in 21 counties and Baltimore City.

The campaign was sponsored jointly by the Medical and Chirurgical Faculty and the Maryland State Department of Health, with the endorsement and support of local health departments



Dr. Karl M. Green, chairman of the Measles Steering Committee administering vaccine at the Emmittsburg Clinic.

and component medical societies, the Jaycees and hundreds of community volunteers.

The campaign was guided by a joint Health Department/Medical and Chirurgical Faculty Steering Committee headed by Karl M. Green, MD and including Raymond L. Clemmens, MD; Murray M. Kappelman, MD; Lawrence C. Pakula, MD; Robert Yim, MD; Benjamin D. White, MD; John H. Janney, MD; John L. Pitts, MD; Robert E. Farber, MD; Margaret Sherrard, MD; Daniel Finucane, MD; and Mr. Humphrey Ridgely.

Planning and coordination of the campaign became the responsibility of the State Health

Department's Immunization Project staff, with every member of the Division of Communicable Diseases staff ultimately involved.

The Medical and Chirurgical Faculty allocated up to $15,000 from its educational fund for education and publicity. These funds made possible the purchase of the many printed materials and other promotional items needed for such a large scale campaign.

In each political subdivision, local health departments and component medical societies planned and conducted clinics using fire stations, schools, shopping centers, health departments, and hospitals as clinic sites.

The campaign was conducted on three Sundays in May, 1967.

LOAN OF JET INJECTORS

The vaccine used was Schwarz Strain (further attenuated). The vaccine was administered, in most cases, by jet injector immunization devices. These instruments were made available by the National Communicable Disease Center in Atlanta, the U. S. Department of Defense, the Health Department of Puerto Rico, and military and industrial organizations in the region.

In all, more than 100 jet injectors were lent to the End Measles Menace campaign. To appreciate fully the generosity of the leaders one should consider that these jet injectors cost approximately $1,000 each.

Personnel to provide maintenance and technical assistance came from Puerto Rico, the District of Columbia, North Carolina, Oklahoma, New York, Illinois, and the National Communicable Disease Center. In addition, personnel in the Venereal Disease sections of the Baltimore City Health Department and Maryland State Health Department were trained to service and operate the injectors. The Maryland State Police helicopter was placed on standby alert for emergency transport of injectors, vaccine and personnel.

PHYSICIANS TRAINED FOR EMERGENCY

One fringe benefit of the End Measles Menace campaign is that more than 250 Maryland physicians have been trained in the operation of the jet injectors. They now are prepared to participate in any future mass vaccination campaign or any emergency situation that may require wide-scale, rapid immunizations.

Physicians who directed the clinics and operated the jet injectors were among the many community leaders who generously donated their time, services, and expertise to the campaign.

Use of the jet injectors was a major factor in the ability to conduct the campaign on an economically sound basis.

Many months in advance, project staff members had computed the probable campaign costs. Factors weighed included the expected percentages of preschool children who would attend the clinics (for these, the U. S. Public Health Service would pay the cost of the vaccine). Vaccine for school children would have to be purchased from donations, as would all clinic supplies for all age groups.

Use of the jet injectors permitted the use of vaccine packaged in fifty dose vials, resulting in greater economy and ease of administration.

VACCINE FOR ALL CHILDREN

Despite this economy and the donation of valuable time and costly services, it was necessary to ask for a donation of one dollar per child from those parents who could afford it. The steering committee, through all of the campaign publicity, made it clear that no child would be refused a vaccination for financial reasons, and provision was made for children of families on Maryland's Medical Assistance Plan.

Careful planning and budgeting, free vaccine for the pre-school children, absorption of certain costs by the State and local health departments, and the Medical and Chirurgical Faculty's financial contribution for education and promotion made it possible for the End Measles Menace campaign to show a surplus of slightly over $5,000.

This surplus has been earmarked as a designated fund for future joint immunization or public health projects of the Medical and Chirurgical Faculty and State Department of Health.

The campaign fell short of its goal of vaccinating the estimated 200,000 susceptibles in the 1-9 age group. While there has been some concern expressed that the estimates of susceptibles were too high, subsequent surveys and spot checks would seem to bear out the validity of the original estimates.

MOP-UP CAMPAIGN IN SCHOOLS

Because of this backlog of unimmunized measles susceptible children, the Division of Communicable Diseases, Maryland Department of Health, has proposed an in-school vaccination mop-up campaign. This campaign would seek to immunize those children in kindergarten, grades one, two, three, and four, and ungraded classes, who are still susceptible to measles; and by so doing to prevent them from carrying the measles virus home to younger siblings.

The following table points up the need for an in-school program on a county by county* basis.

SURVEILLANCE

With the goal of measles eradication so close, surveillance becomes a matter of extreme concern. Prompt reporting of suspected measles cases will enable health officials to pinpoint and then immunize those children who have not received the measles vaccine. Surveillance will enable health officials to squelch possible epidemics before they occur.

*Baltimore City is not included in these figures. An independent survey and estimate places enrollment in *inner city* ungraded, kindergarten, first, and second grades at 11,971 in 60 public schools. Susceptibles since the May campaign are estimated to be 4,000. It is emphasized that these figures represent only inner city school children. A projection for the total city enrollment is 10,000 susceptibles.

SCHOOL CHILDREN IN THE COUNTIES OF MARYLAND*
SUSCEPTIBLE TO MEASLES
(un-graded, 1st, 2nd, 3rd and 4th grades)

Counties of Maryland	Children Enrolled	Estimated Susceptibles Before Campaign	Number Vaccinated in Campaign	Estimated Susceptibles After Campaign	Estimated Susceptibles Now
Allegany	6,713	1,477	911	566	509
Anne Arundel	26,998	9,125	2,583	6,542	5,888
Baltimore	54,414	10,339	4,375	5,964	5,368
Calvert	2,191	741	150	591	532
Caroline	1,872	633	287	346	311
Carroll	5,471	1,849	832	1,017	915
Cecil	5,083	1,718	392	1,326	1,193
Charles	4,994	1,598	690	908	817
Dorchester	2,354	796	390	406	365
Frederick	7,361	2,489	474	2,015	1,813
Garrett	1,931	637	92	545	490
Harford	10,156	1,930	1,030	900	810
Howard	5,416	1,831	567	1,264	1,138
Kent	1,456	492	282	210	189
Montgomery	46,162	6,693	4,015	2,678	2,410
Prince George's	55,869	18,884	5,777	13,107	11,796
Queen Anne's	1,679	568	233	335	301
St. Mary's	5,015	1,103	553	550	495
Somerset	1,688	571	351	220	198
Talbot	2,017	682	209	473	426
Washington	8,194	3,196	1,318	1,878	1,690
Wicomico	5,131	1,734	522	1,212	1,091
Worcester	2,359	797	403	394	355
TOTAL	264,524	69,883	26,436	43,447	39,100

PROBLEMS IN THE RECOVERY OF STROKE PATIENTS

ALBERT F. HECK, MD
Assistant Professor
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Co-Director, Stroke Clinic
University of Maryland School of Medicine

An estimated two million people living today in the United States have had one or more strokes.[1] Cerebrovascular disease is one of the three great killers of Americans, ranking closely behind heart disease and cancer. While 80% of deaths from this condition occur in those over 65, among persons less than 65, stroke is the fifth commonest cause of death of those in their most productive years.[1]

Dry statistics do not reflect the misery and loss of human dignity, nor the social, financial and psychological burdens imposed by a condition which, when detected in its earlier stages, is amenable in many cases to preventive therapy. The sequelae of stroke may in many cases be greatly ameliorated by prompt, correct diagnosis, careful treatment in acute stages and by proper application of physical, medical and rehabilitative measures in the majority of patients surviving the acute illness.

Stroke may be defined as dysfunction of one or more areas of the nervous system, resulting from a deficiency between the metabolic demand and the metabolic supply to the area, this occurring at least in part on the basis of disease of the cardiovascular system.

This broad definition not only encompasses the classical categories of thrombosis, hemorrhage and embolization, but also points to the many factors and wide variety of pathological processes which may be contributing to the clinical picture of stroke in the individual patient. Any process compromising the flow of blood to the brain, the content of essential brain metabolites in the blood, or the patency of the blood vessels to the brain—eg reduction of cardiac output, fall in blood pressure, reduction in oxygen content of the blood, hypoglycemia, atherosclerotic plaques, arteritis, emboli—in the presence of localized disease of blood vessels in the brain, causes dysfunction of those areas of the central nervous system supplied by the affected vessels.

Symptoms and signs are specifically referable to the areas of the brain involved. They vary widely in their extent, severity and duration, depending on the vessel involved, the nature of the underlying pathological process, the state of collateral blood supply to the area affected and the presence, absence or duration of systemic factors tending to compromise cerebral blood flow or the metabolic content of the blood. Factors predisposing to stroke—diabetes, heart disease, hypertension, vasculitis, anemia, arteriosclerotic stenosis of great vessels in the neck and upper chest—must be evaluated and treated in their own right. Detection and correction of the many possible factors involved is most profitably directed to the patient in whom the combination of predisposing and precipitating factors exist briefly enough that no permanent damage results to the brain—the so-called "transient ischemic attack" or *TIA*.

Where permanent damage to the brain has occurred, however, it is perhaps equally significant that among the majority of the 80% who survive their acute illness, a variable degree of improvement toward normal function is to be *expected*. Where improvement does not occur there is a reason. Awareness by the physician of these reasons and of the avoidable complications to which stroke patients are predisposed may lead

to a significant reduction of morbidity in the individual patient.

Hemiplegia is the commonest motor manifestation of stroke. With onset, there is weakness, loss of reflexes and flaccid loss of muscle tone. After a variable time, the familiar hyperactivity of reflexes, spasticity of muscle tone, appearance of pathological reflexes (eg Babinski) and some improvement in strength is to be expected. As a rule, the sooner the appearance of spasticity and hyperreflexia after onset, the better the prognosis for return of function. Hypotonia and hyporeflexia may persist and compromise attempts at rehabilitation and gait retraining. Persistence of flaccidity should suggest to the physician that he has perhaps overlooked one of the predisposing or precipitating causes responsible for prolongation of the metabolic deficiency underlying dysfunction of brain tissue. Damage to the parietal lobe, with which persistent flaccidity is sometimes associated, may result in disturbances of recognition of shapes and symbols, confusion of right and left, impaired tactile discrimination, reading, writing, calculation and other functions which have immediate bearing on rehabilitation to a useful existence. Recognition of these disturbances may pinpoint the source of problems encountered in recovery and retraining and aid in the definition of more realistic goals in rehabilitation of individual patients.

Urinary incontinence requiring catheterization is a common and often severely debilitating problem in neurological disease. Prolonged catheterization is fraught with several complications, most of which are entirely preventable and all of which are treatable. Of these, infection is the commonest and potentially the most dangerous, particularly in diabetics, who are unfortunately also predisposed to atherosclerotic cerebrovascular disease. In the absence of pre-existing genitourinary pathology, practically all patients can be maintained free of infection—urethritis, prostatis, cystitis and ascending pyelonephritis—by 1) avoidance of unnecessary trauma to the lower G.U. tract and 2) meticulous attention to internal asepsis and external cleanliness. Trauma to the urethra and/or prostate gland, a significant precipitant of infection, can be minimized; repeated trauma by "routine" changing of catheters is not necessary if catheters are cleaned externally and irrigated prn. with Solution "*M*" or "*G*". Deposition of urinary concretions in the catheter, easily palpable by rubbing the tube between the fingers, is an indication for replacement. In males, dependence of the penis in its usual position with a catheter in place results in pressure in the intrabulbar fossa of the urethra and may result in a urethro-perineal fistula, a serious complication requiring surgical intervention. This may be avoided simply by strapping the catheter to the abdomen so that the penis points craniad. In males, where residual urine volume after voiding is not excessive (vide infra) problems of urethral trauma from catheterization may be averted by use of an external collecting device fashioned from a condom fastened and inverted over a tube, but this too requires meticulous attention to cleanliness of the genitalia and avoidance of excessive constriction.

Where bladder dysfunction is permanent, bladder rehabilitation, aimed at eventual removal from reliance on a catheter, should be begun as soon as possible, but only in the *absence* of infection, of bladder hypotonia or of vesico-ureteral reflux. Catheters, once in place, are best left on straight drainage. Periodic clamping of catheters in an effort to preserve bladder tone may result in infection complicating urinary stasis.

Cystography and cystometography are often necessary for proper evaluation. Following voluntary or reflex voiding, a residual urinary volume of 20% of the total bladder capacity as measured by cystometography is the maximum acceptable value if one contemplates removing the catheter. A high residual volume may result from 1) spasticity of the bladder sphincter with obstruction to urinary outflow or 2) hypotonia of the bladder wall with reduction of voiding pressure. In patients without catheters, urinary frequency with oliguria and "overflow" incontinence are the usual results of a spastic bladder sphincter. This may be not only socially debilitating, but also a major nursing problem. Spastic bladder sphincter is often amenable to one of several urological procedures, including pudendal nerve blockade or sphincterotomy. The latter situation, ie spastic sphincter, must be differentiated from that in which urinary urgency and evacuation of small urine volumes occur on the basis of hyperactivity of the stretch reflex of the bladder wall itself. This hypertonicity of the bladder detrusor is

detected by means of cystometography and is best treated by removal of the catheter together with administration of small amounts of anticholenergic drugs (Pro-banthine *Propantheline*).

The use of prophylactic antibiotics in the absence of infection is usually not indicated and may result only in a stubborn infection by a resistant organism if and when infection does occur. Suppressive therapy, however, including *Mandelamine* or *Furadantin*, together with a urinary acidifying agent such as *Methionine* (Pedameth) or an acid phosphate preparation (*pHos-pHAaid*), is helpful in controlling bacturia and urinary encrustations.

In stroke some degree of spasticity is an expected concomitant in the recovery of hemiplegia. Imbalance of muscular tone, with hypertonicity of flexor, pronator and adductor muscles in the upper extremity, of extensors, external rotators and adductors of the thigh and of invertors and plantarflexors of the foot, lead to the characteristic attitude of the extremities and the circumducting gait of the hemiparetic. Left untreated, hypertonicity may in a short time lead to contractures more disabling than the weakness involved. Protracted adduction and internal rotation of the shoulder joint in particular may lead to a stubbornly painful "frozen shoulder." Flexion contractures of the fingers and wrists render the hand all but useless and contractures of the ankle in inversion and plantar flexion seriously impair gait retraining.

Movement of all joints through a full range of motion three or four times a day as soon as such tone reappears following stroke will effectively prevent these complications. Passive movement may be carried out by untrained family members or indeed by the patient himself, using his unaffected side. Particular attention should be paid to the shoulder joint which, because of its unique anatomical structure (ie a ball joint held in position entirely by muscle and tendon), is peculiarly susceptible not only to painful contractures but also to dislocation by too vigorous manipulation, particularly during the flaccid stage of paralysis.

In the acutely ill patient, limb contractures are combated by proper position with a foot board and sand bags applied to the sides of the lower extremity to prevent plantarflexion and external

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rotation of the limb; pillows should *not* be placed under the knees as this encourages flexion contracture of the leg on the thigh. The arm can be effectively maintained in an abducted, pronated position by padding it into a soft pillow and the fingers extended by bandaging them lightly with cardboard I-V tubing container.

Decubitus ulceration is almost always preventable and results from the combination of three predisposing factors: 1 uneven pressure against the skin, 2 wetness and 3 negative nitrogen balance. Infection is frequently superimposed and impairs healing. Avoidance of unevenness of bed clothes and mattresses, frequent turning of the patient, dryness of the skin and bedclothing and padding of bony prominences (eg sacrum, elbow, greater trochanter, malleoli, heels) will prevent bedsores even in the severely debilitated patient.

In the bedridden patient, particularly those in the older age groups, prolonged lack of weight bearing accelerates demineralization of bones, predisposing to fracture and to formation of mineral deposits in the GU tract. This can be avoided by early ambulation where possible; where this is not feasible, dietary restriction of calcium intake and weight bearing by the patient in a standing position while secured to a footed board or tilt table will reduce these complications.

Among patients admitted to longterm hospitals and outpatient facilities devoted to rehabilitation in the State of Maryland, the complications mentioned above are frequently encountered and are often responsible for prolongation of treatment with avoidable expense to families of patients and to the State. Urinary tract infection, requiring treatment, may preclude bladder rehabilitation for several weeks or indefinitely. Decubitus ulceration or severe contractures may delay physical and vocational rehabilitation of patients by four to six months.

An awareness on the part of physicians and other medical personnel of the natural course and possible complications to be anticipated in patients suffering from cerebrovascular disease is a prerequisite to planning proper management and meaningful therapy. The application of preventive and supportive therapy at the proper times can reduce the morbidity and mortality of this common condition and hasten the maximum degree of return toward a less dependent, more useful and happier existence for the patient.

The author is indebted to John D. Young, Jr., MD, Professor and Head, Division of Urology and Paul F. Richardson, MD, Associate Professor and Head, Division of Physical Medicine and Rehabilitation, University of Maryland School of Medicine for their comments and suggestions in the editing of this manuscript.

Supported in part by *NINDB* Grant *NB* 06779

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1. A National Program to Conquer Heart Disease, Cancer and Stroke. Vol. I *The President's Commission of Heart Disease, Cancer and Stroke*, U. S. Government Printing Office, Washington, D. C., 1964, page 12.

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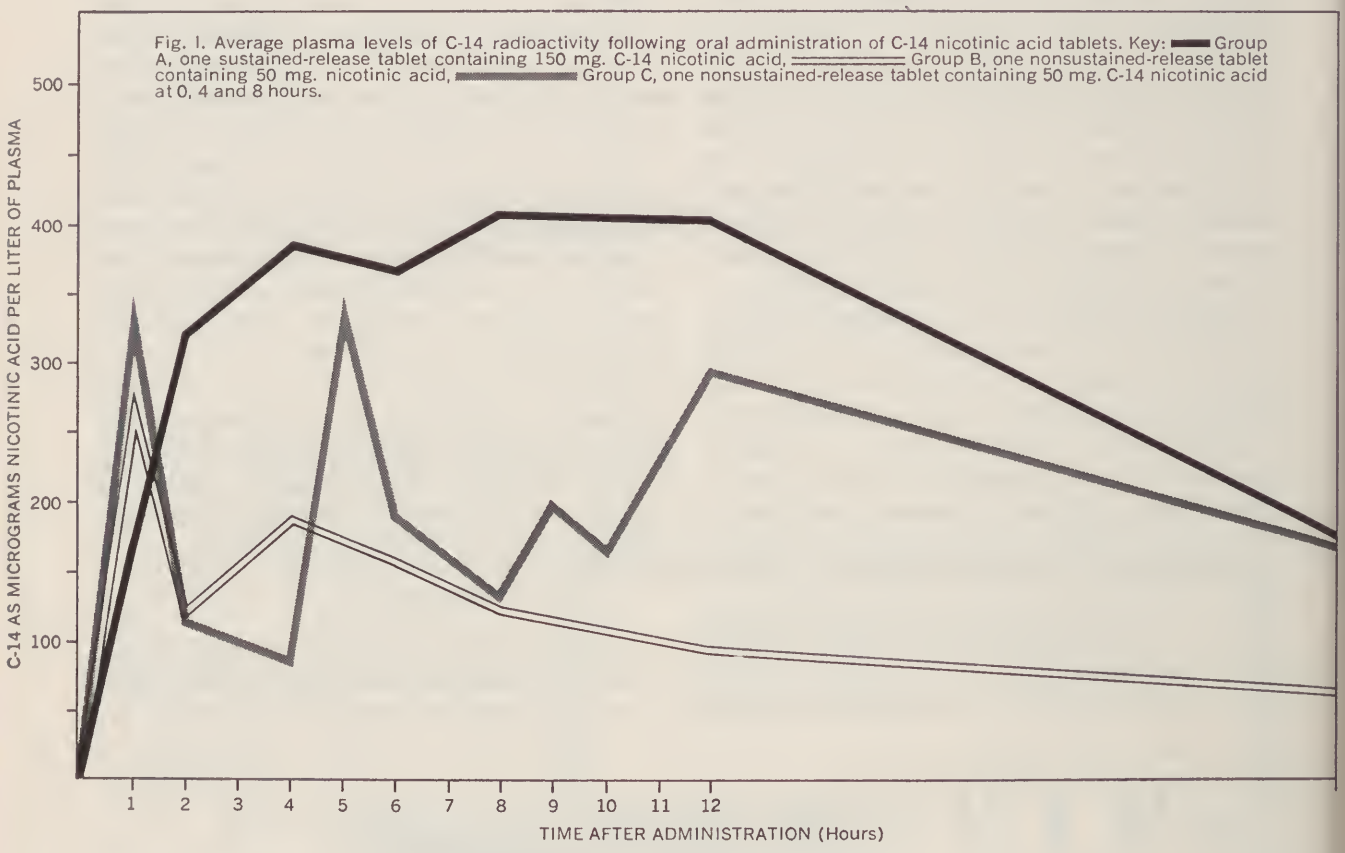
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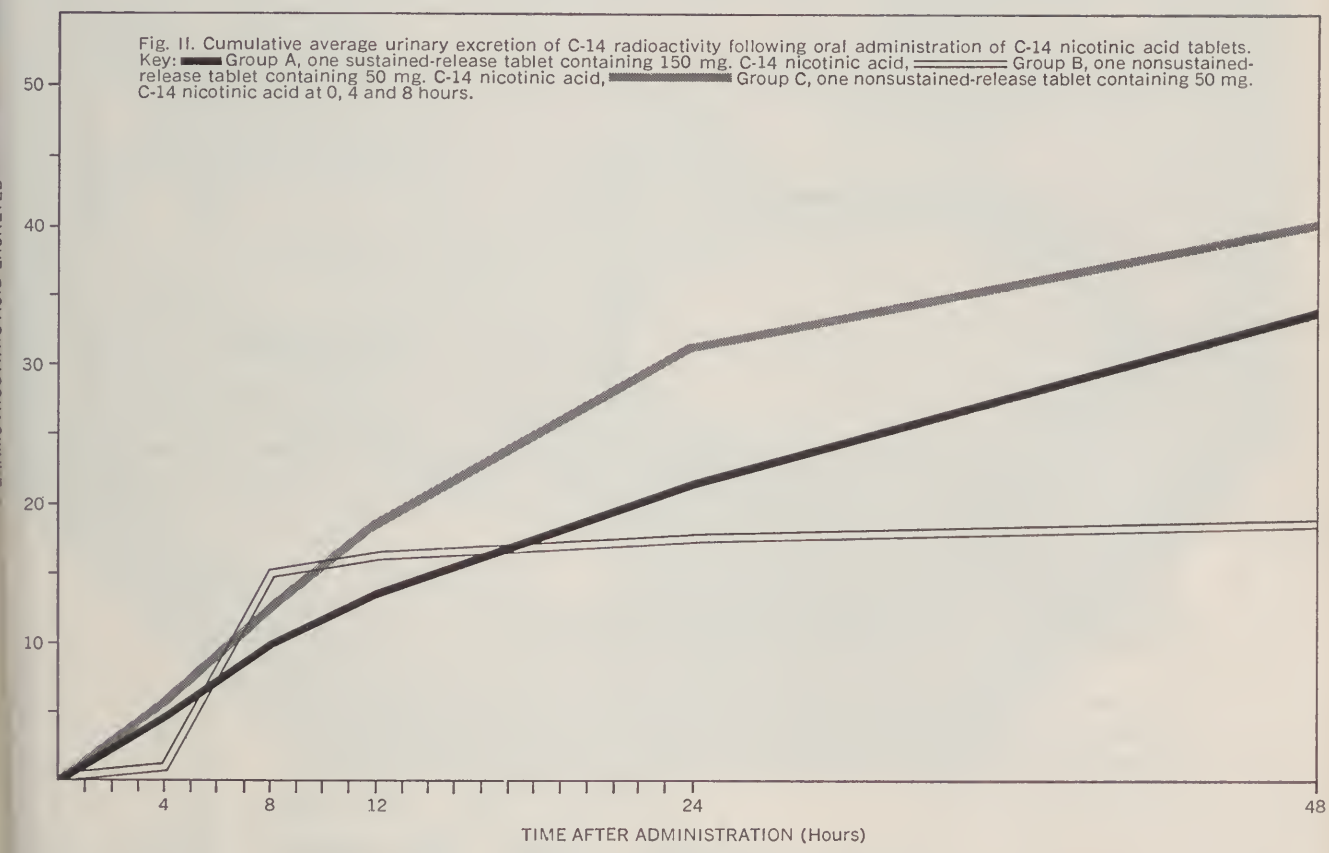
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References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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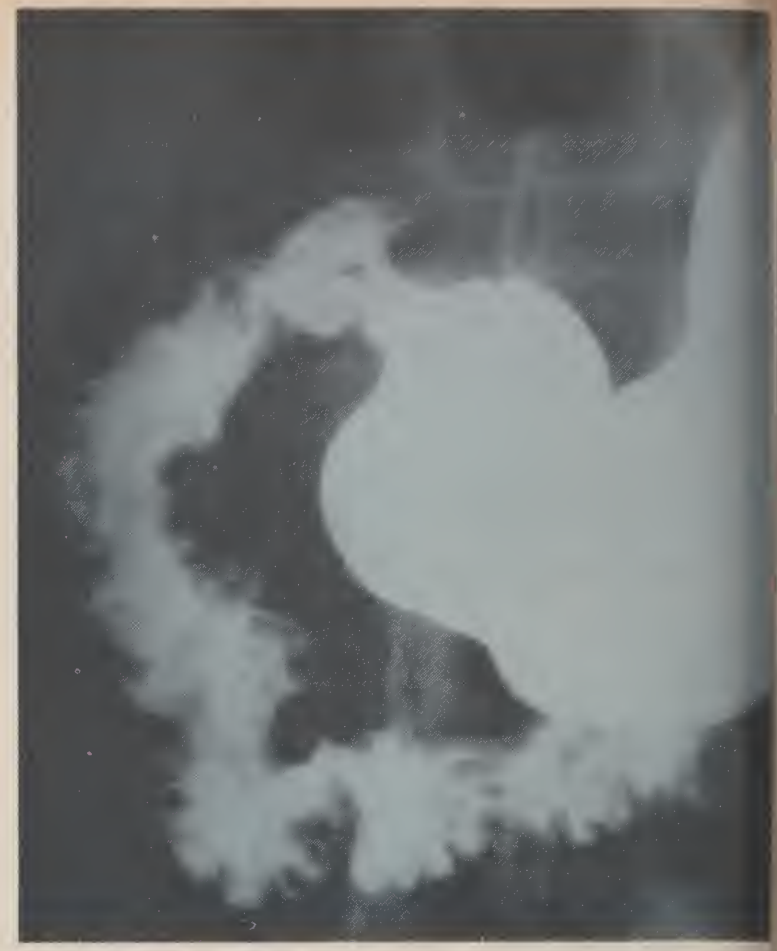
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(1) Bilbao, M. K.; Frische, L. H.; Rösch, J., and Dotter, C. T.: Hypotonic Duodenography, Scientific Exhibit, Radiological Society of North America, Chicago, Nov. 27–Dec. 2, 1966.

(2) Bilbao, M. K.; Frische, L. H.; Dotter, C. T., and Rösch, J.: Hypotonic Duodenography, Radiology, in press.

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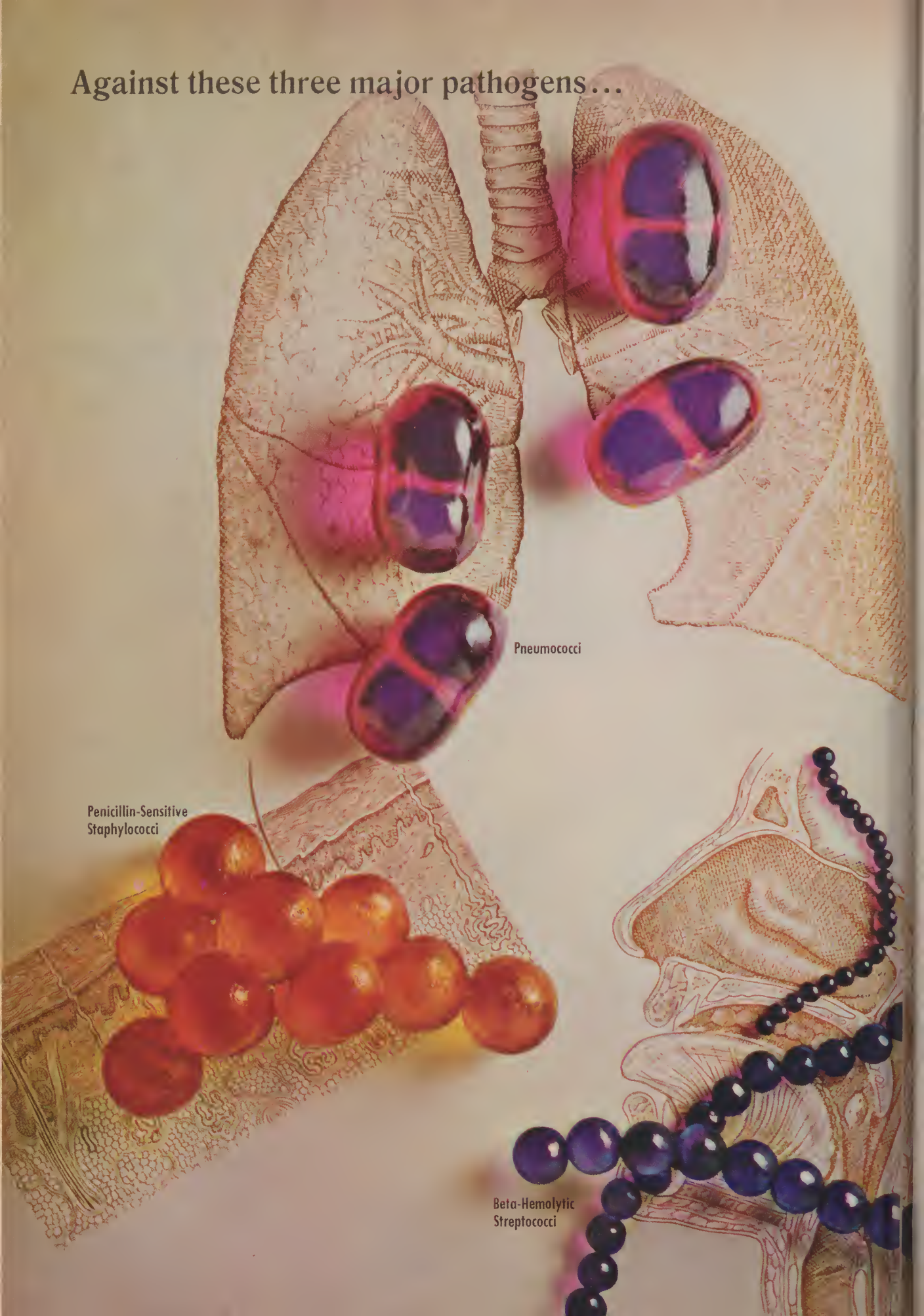


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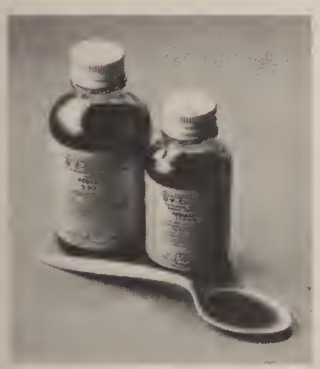
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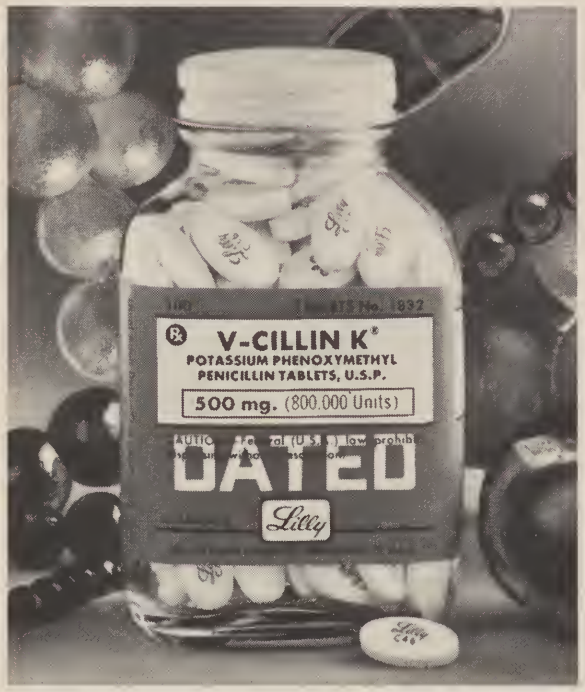
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Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

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Failure to Isolate Causative Organisms

Some Thoughts on the Failure to Isolate Causative Organisms in Patients with Endocarditis or Why Aseptic Endocarditis

RICHARD B. HORNICK, MD
Director, Division of Infectious Diseases
University of Maryland School of Medicine

Patients with bacterial endocarditis frequently present vexing diagnostic and therapeutic problems. The classic manifestations of infection may not be present or else misinterpreted. This can result in inappropriate therapy which may further complicate proper interpretation of the clinical data by interfering with isolation of the offending organism. The prime prerequisite for effective therapy is a complete knowledge of the antibiotic sensitivity of the causative organism. Therapy guided in part by this important laboratory procedure and in part by the peculiarities of the host will provide the best therapeutic results.

Bacteremia in the typical case of endocarditis is usually continuous so that only a few carefully obtained blood cultures are sufficient to demonstrate the causative microorganism. Unfortunately some patients, 5-15%, who present with the clinical manifestations of endocarditis will show persistently negative blood cultures. The most common obstruction to bacterial isolation is the effect of a chemotherapeutic agent. Antibiotics administered to patients prior to hospitalization because of suspected febrile infectious disorders will interfere with the isolation of many of the causative agents of subacute bacterial endocarditis. The presence of low concentration of antibiotic may inhibit growth of bacteria from a specimen of blood without having any significant beneficial effect on the primary infection of the endocardium. Moreover, penicillin given prophylactically to patients with rheumatic heart disease can delay or prevent the isolation of organisms from the blood. This is especially true when the infection is caused by a viridans streptococcus that is moderately sensitive to penicillin.

Equally important as a factor influencing results of blood culture is the type of offending microbe. The presence of unusual organisms which require special cultural techniques for isolation may often create the clinical picture of "abacterial endocarditis." Examples of such organisms are those which require a strict anaerobic environment. In this category are enterococci, some streptococci and less common species of bacteroides. Anaerobic streptococci are probably the most common types of offending bacteria in those cases of enrocarditis from whom the organ-

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ism is not isolated. Other fastidious organisms may cause endocarditis and are isolated with difficulty. The gonococcus is very elusive when attempts are made to isolate it from the blood. Fortunately this "bad actor" is an unusual cause of endocarditis. Other unlikely causes of endocarditis which are not amenable to isolation with routine techniques are *Histoplasma capsulatum, Coxsiella burneti* and brucellae. These are rare examples of agents which cause endocarditis but their identification is important because of the special therapeutic requirements inherent in their eradication. Those patients whose clinical features are compatible with endocarditis and whose course is refractory to ordinary measures should have elaborate cultural techniques performed to rule out such agents.

Occasionally patients with the clinical diagnosis of endocarditis will have blood taken for culture which subsequently is reported to show diphtheroids or a "contaminating staphylococcus." These findings should not be hastily rejected nor should they be accepted without question. These organisms may cause endocarditis in certain circumstances (ie after heart surgery). Furthermore, the causative microbe such as species of Listeria may be confused with diphtheroids and be reported as such. Usually diphtheroids and non-hemolytic staphylococcus are contaminants; contamination occurs often due to improper aseptic techniques when blood is drawn and placed in the culture flasks. Evidence in favor of accepting these organisms as true etiological agents requires their growth in media within 24-48 hours and their presence in more than one blood specimen.

Two other possibilities are responsible for difficulties in isolating causative agents in endocarditis. Prior administration of an antibiotic such as penicillin interferes with the isolation of certain bacteria. One of the mechanisms for this failure of bacterial growth is the ability of penicillin to produce incomplete organisms, such as "L" phase bacteria which lack a cell wall. This phase of bacterial growth appears to be normal for most bacterial species but requires special media for its demonstration. Penicillin is one of several environmental forces that causes bacteria to assume deviation to the "L phase." "L phase" organisms probably are non pathogenic for man (further proof is needed on this point) but may serve as a future source of virulent bacteria through reversion to fully complemented organisms in a proper tissue environment. These bacterial forms have been isolated from patients with endocarditis while receiving penicillin. In several instances such incomplete bacteria appeared to perpetuate the infection despite penicillin treatment. Only when chemotherapy was directed against them did clinical recovery occur. As additional evidence accumulates regarding these interesting organisms present concepts of proper antibiotic management of endocarditis may have to be altered. Additional drugs may have to be added to the therapeutic regimen. Moreover, it may be possible to shorten the prolonged course of parenterally administered antibiotics. These points are highly speculative and further experimental, clinical and microbiological verification is needed.

Finally, evidence of viral induced endocarditis in mice has been reported recently. No such human examples have yet been demonstrated but instances of "abacterial endocarditis" have been observed at autopsy. Identification of viral cause is difficult but not insurmountable.

Summary

In summary an attempt has been made to enumerate some of the possible explanations for negative blood cultures in patients with a clinical diagnosis of endocarditis. Only with this *prima-facie* evidence of disease can specific therapy be administered. Without such evidence antibiotic treatment should be given only when the clinical picture is strongly suggestive of endocarditis and other diagnoses have been ruled out. Once initiated, the clinician is usually obligated to provide a full course of antibacterial treatment.

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Pediatrics

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Pediatric Habilitation—The Doctor's Role

GEORGE A. LENTZ, JR., MD
Assistant Professor Pediatrics
Instructor Physical Medicine and Rehabilitation
University of Maryland School of Medicine

Much has been written recently about the team approach and the role of the various disciplines in the management of a child with a chronic disorder. In this area of habilitation, what is the doctor's role? What contributions can and should he make?

Progress in medicine has brought about great changes in the care of children over the first half of this century. With the development of vaccines, and the emphasis on prevention, more and more infectious diseases are relegated to a position of minor importance. Furthermore, the early recognition, diagnosis, and treatment of many conditions has greatly altered the mortality and caused a shift from the management of acute illnesses to concern and management of chronic, disabling diseases and effects. The recent developments in the early surgical treatment of infants with meningomyelocele is one example. The increasing number of learning disabilities and behavioral problems that require complicated remediation are also problems. The role of the family physician in child care has been altered. Instead of having a seemingly lesser role in child care he is called upon to assume a more complex role as advisor, counselor, and coordinator.

A child is considered handicapped if he has a disability that limits or interferes with his work, his play, his education, his social activities, and his contributions to his home, family, and community. The field of habilitation is, therefore, the alleviation or alteration of disabilities so that they will be less of a handicap. This process of habilitation would allow the child to develop to the highest potential in all areas of life's endeavors. Lest he feel he is dealing with a small number of individuals, the physician should be reminded of the numerous studies that indicate that approximately 12 to 15% of school age children have disabilities that interfere with their growth and development in the educational sphere. In a recent report, an estimated 62,000 Maryland school age children will require special educational assistance in the year of 1968.

In a publication of the Maryland State Health Department,[2] an excess of 240,000 youngsters, approximately 1 in 7, are identified as having various chronic disorders. In Baltimore alone, there are estimated at least 1,500[1] youngsters affected by the rubella epidemic of 1964-65. These youngsters have many needs to be fulfilled to

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allow them to grow to their highest potential. The magnitude of chronic disabilities the physician and the community face is generally unrealized. These youngsters and their parents require a great deal of the practitioner's time, understanding, support, and counsel.

One of the most important roles of the physician is early recognition and diagnosis. In this diagnostic role, it is not enough to list or label the conditions that are present. Rather, it is vital that a descriptive and functional evaluation be made that can be easily translated and used by the members of the remediation team. Many times the medical terminology and jargon is not well understood or practical to the therapist or teacher.

In pediatrics one is primarily concerned with growth and development, and in no instance is it more important than in the field of managing a handicapped child. A disabled child is an individual with varying degrees of growth potential. The influence of growth and development on his disability and the effects of the disability on growth and development must be understood. Every child is a constantly changing individual in a constantly changing environment. A youngster with a disability is no exception. Rather, he presents many special problems. The physician must keep these things in mind and must be able to interpret what the disability means to the child, his parents, his peers, his neighbors, and to others who are concerned with his welfare.

Having made a diagnosis and keeping the basic principles in mind, the physician's next role is to take an active part in long range planning and goal setting. The important point here is the long range aspect of things and the realistic approach. To make realistic plans one must be aware of the recent developments and the services and programs available. In this planning, the physician might keep in mind Kipling's faithful men—*Who, What, When How, Where,* and *Why.*

In the past decades, there has been phenomenal growth of allied health professions. In a recent article appearing in the *AMA* News, the ratio of para medical personnel to physicians was listed as 4:1. This figure is expected to increased to 7:1. These individuals are highly specialized in their area of competence and have an enormous contribution and role to play in the management and care of the handicapped child. Just as the physician knows the qualities and capabilities of his medical colleagues, it is equally important that he knows the capabilities as well as the limitations of these specialists. The physician's training, unfortunately, generally has been somewhat limited in this area and he should overcome this deficiency. It is of utmost importance that he be able to communicate with and enlist the aid of the many members of the rehabilitation team. He must engage in interdisciplinary discourse so that all may be able to "grow up together" in this field of pediatric rehabilitation. The great diversity and specialization presents many problems. Many youngsters move from clinic to clinic and from specialist to specialist often with little overall direction and coordination. Again, we see the need of a generalist. Realistic goals must be set, realistically reevaluated, and someone must be able to see "the forest from the trees." Therefore, the physician has a role of a navigator or helmsman in guiding the rehabilitation course.

New concepts of remediation and new programs are being developed at a very rapid rate. Many times the efficacy of the program is evaluated by the same discipline that proposed or is engaged in the implementation. It is mandatory that critical, objective, scientific evaluation of these programs be performed. Intradisciplinary evaluation and research seems indicated. Thus, another role of the physician is to give of his time and talents in the scientific evaluation of various methods of treatment and remediation.

Handicapped children arouse great emotions in all of us—parent, therapist, educator, and physician. As a professional, physicians are trained to be objective. We must let emotion concern guide but not overwhelm us. There are many vital roles the physician can and must play.

The purpose of this article has been hopefully to arouse the physician as to the scope of the problem, the needs, the services available, and most importantly the roles he must play as coordinator, counselor, teacher, and scientist in the care and management of a child with a disability.

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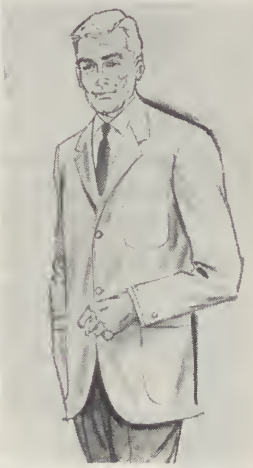
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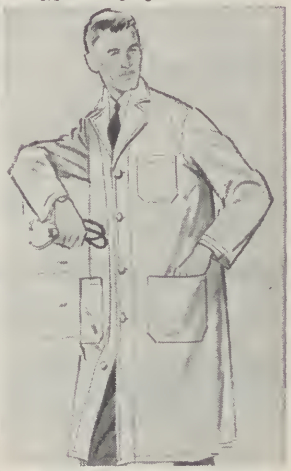
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Highlights

GENETICS SEMINAR HELD

The role of public health workers in the field of medical genetics was examined recently in a one-day seminar on "Medical Genetics in Public Health," sponsored jointly by Moore Clinic, Division of Medical Genetics, the Johns Hopkins Hospital, and the Health Department's Division of Mental Retardation. The program, under the supervision of Victor A. McKusick, MD, Professor of Medicine at the Moore Clinic, included presentations on general principles of genetics and genetic counseling, as well as, specific information on phenylketonuria, muscular dystrophy, mongolism, and cystic fibrosis.

BULLETIN UNDERGOES FACE-LIFTING

The Maryland Department of Health Bulletin, published since 1929, has been revamped and retitled "Maryland's Health." It will be issued quarterly, rather than bimonthly, in a magazine format suitable for hospital and office library or waiting room use. Major public health programs and problems in the state will be featured. The first issue in the new format dealt with the recent Measles Immunization Project carried out in cooperation with the Faculty.

REFERENCE HANDBOOK AVAILABLE

A new handbook describing Health Department services throughout the state has been published. Designed for use by physicians and their aides, nurses, social workers and other health personnel, it contains information on available services and their locations which should prove helpful to professional people in advising their patients or clients. Copies may be obtained from the Division of Health Education, 301 West Preston Street, Baltimore, Maryland 21201.

MONTEBELLO SEEKS NURSES

A 36-bed wing of Montebello Chronic Disease-Rehabilitation Hospital was closed last year because of the shortage of nurses. With the recent increase in salary scales, efforts have been rekindled to fill the 21 existing vacancies. When fully staffed, the hospital is able to receive and discharge an average of twelve patients per week. Closing of the wing has reduced this exchange to approximately half, and resulted in a sizeable waiting list of patients needing the special rehabilitative services of the hospital.

MEDICAL ASSISTANCE INPATIENT PAYMENTS INAUGURATED

Physicians requesting information on the new program of payments for services rendered in hospitals to patients certified eligible for Medical Assistance have received billing forms and a manual listing medical and surgical procedures by code number. Procedure listings conform in general to the nomenclature recommended by the American Medical Association and Blue Shield. To help in estimating the amount which should be included for this program in future Health Department budget requests, physicians have been

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asked to bill their usual and customary fees. Payments, however, will be calculated and made on the basis of funds presently authorized by the Legislature.

Delays in payments for home and office visits, when they occur, are frequently due to mistakes in entering the 11-digit certification number on the billing form. The Department has requested in its 1969 budget an appropriation for funds to establish a "charge-a-plate" system of stamping bills. If these funds are appropriated by the General Assembly, the factor of "human error" should be greatly minimized.

MEDICAL ASSISTANCE ADVISORY COMMITTEE

To conform with Federal requirements governing Medical Assistance Programs, the State Board of Health and Mental Hygiene established the Medical Assistance Advisory Committee, which met for the first time in March 1967. Its composition includes representatives of the medical, dental, legal and nursing professions, pharmacists, hospitals, medical school faculties, nursing homes, local health and welfare services, Maryland Hospital Service, various segments of the community, the Department of Mental Hygiene, and the Department of Public Welfare. Health Department representatives serve as supporting staff.

Three major program committees to consider the areas of Professional Services, Institutional Services, and Program Development have been formed. Under these are subcommittees concerned with specialized aspects of the program. All committees work closely with Health Department staff members. The recommendations of these committees, if adopted by the committee as a whole, are transmitted to the Board of Health and Mental Hygiene for action. The Board relies heavily on the advice of the Advisory Committee and the State Health Department staff in establishing regulations for Health Department administration of the Medical Assistance Program.

EASTERN SHORE VD PROJECT COMPLETED

The Venereal Disease section of the Division of Communicable Diseases through the summer months conducted a testing and treatment program among migrant workers on the Eastern Shore. Syphilis serology was performed on 1440 blood samples. Positive reactions were obtained in 246 cases, 55 of which left the area before an examination could be performed. Of the remaining 191 cases, 7 were diagnosed as having primary syphilis, 20 as secondary, 27 as early latent and 137 as late latent. Treatment was given in 112 cases, mostly young persons. A companion project still under way in two western counties indicates similar findings.

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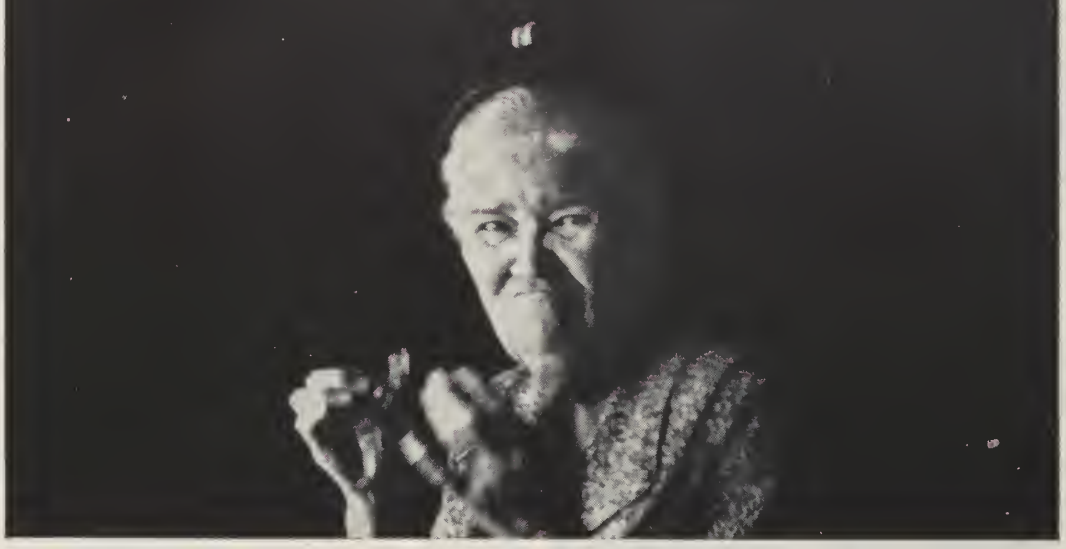
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ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

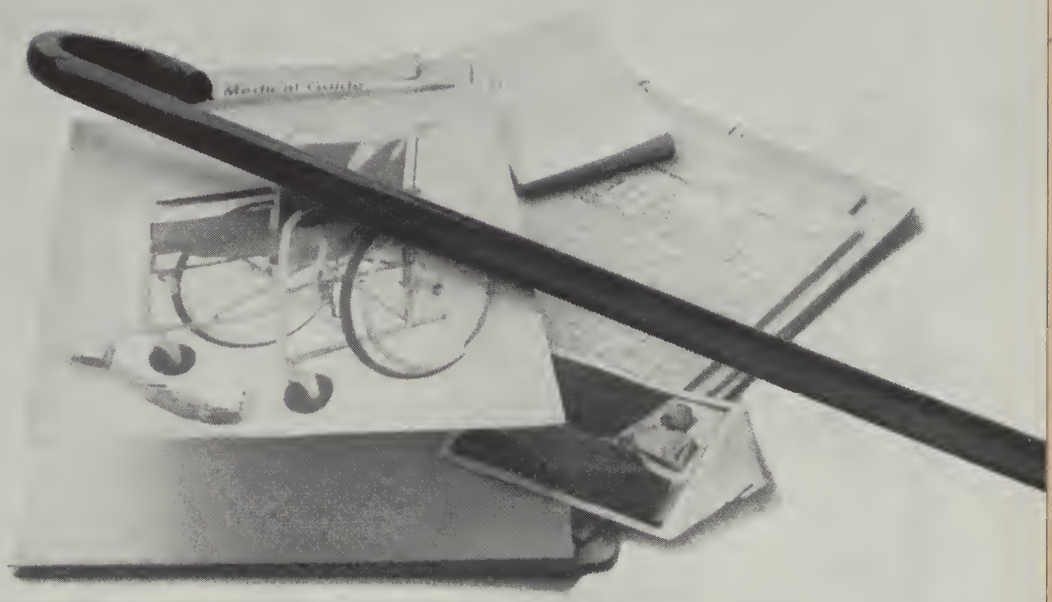
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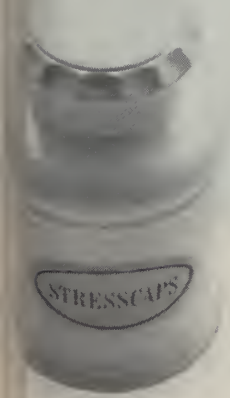
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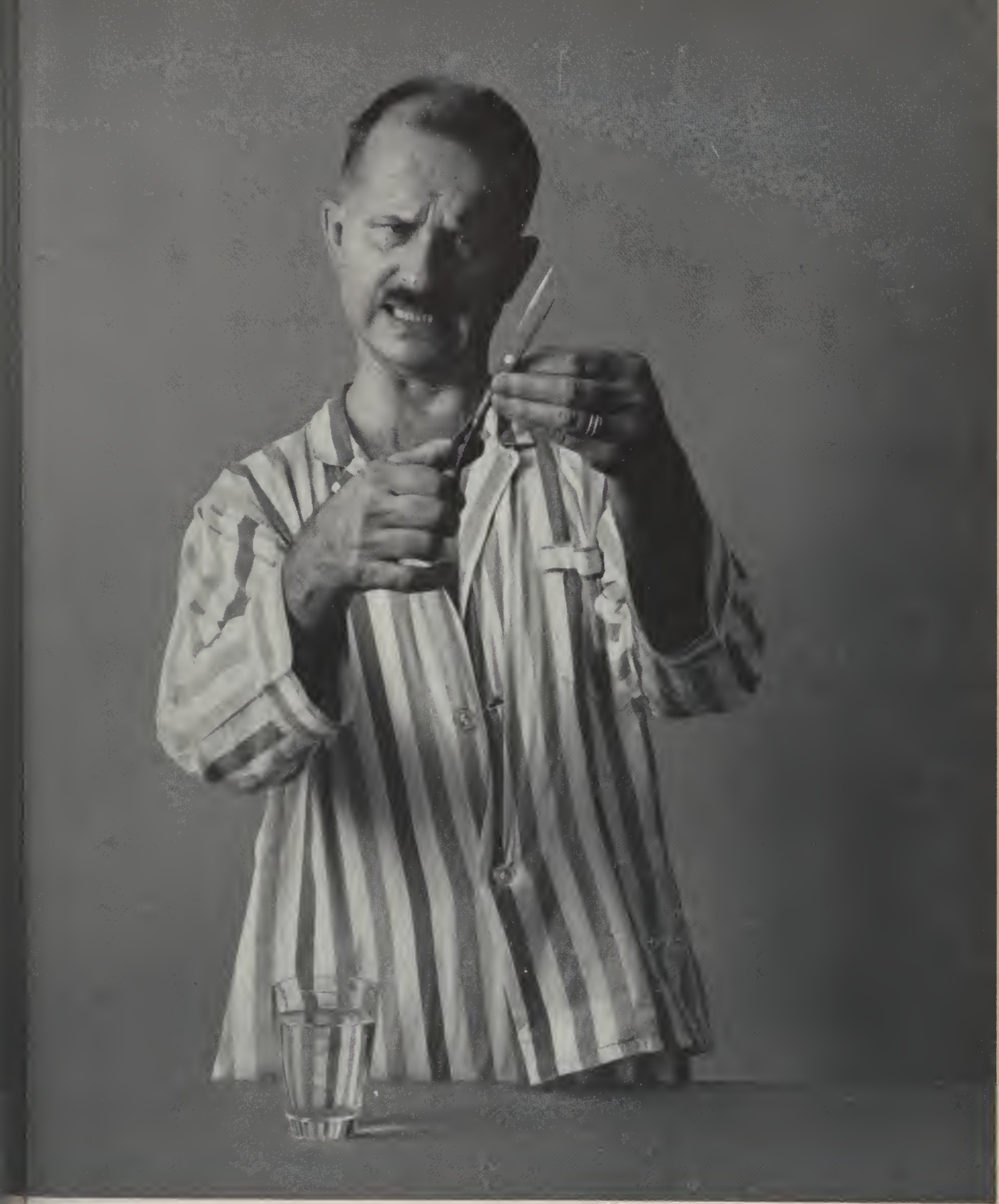
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n s lements immediately if abdominal
, d ention, nausea, vomiting, or gastro-
sti bleeding occur.

wi caution in pregnant patients, since
dr may cross the placental barrier and
ers eactions which may occur in the
t (t mbocytopenia, hyperbilirubinemia,
ed rbohydrate metabolism, etc.) are
nti problems in the newborn.

:au ns: Antihypertensive therapy with
rot should always be initiated cau-
sly postsympathectomy patients and
ati s receiving ganglionic blocking
nts other potent antihypertensive drugs,
ura Reduce dosage of concomitant
hyp ensive agents by at least one-half.
itu es, narcotics or alcohol may po-
ate potension. Because of the possi-
y o rogression of renal damage, peri-
de mination of the BUN is indicated.
on e if the BUN rises or liver dysfunc-
is gravated. Hepatic coma may be
p ed.

tro imbalance, sodium and/or potas-
de tion may occur. If potassium deple-
sh d occur during therapy, Hygroton
id discontinued and potassium sup-
men given, provided the patient does
av harked oliguria.

spial care in cirrhosis or severe
m heart disease and in patients re-
ng rticosteroids, ACTH, or digitalis.
res tion is not recommended.

rse eactions: Nausea, gastric irritation,
tin anorexia, constipation and cramp-
diz ess, weakness, restlessness, hy-
yc ia, hyperuricemia, headache, mus-
ra s, orthostatic hypotension, aplastic
ia ukopenia, thrombocytopenia,
nu ytosis, impotence, dysuria, transient
ia kin rashes, urticaria, purpura, nec-
ing itis, acute gout, and pancreatitis
e astric pain or unexplained G.I.
to develop after prolonged adminis-
on er reactions reported with this
s o mpounds include: jaundice, xan-
sia resthesia, and photosensitization.

age osage: One tablet with breakfast
or ery other day.

ab y: White, single-scored tablets of
g. d aqua tablets of 50 mg., in bot-
of 1 and 1000. (B)46-230-D

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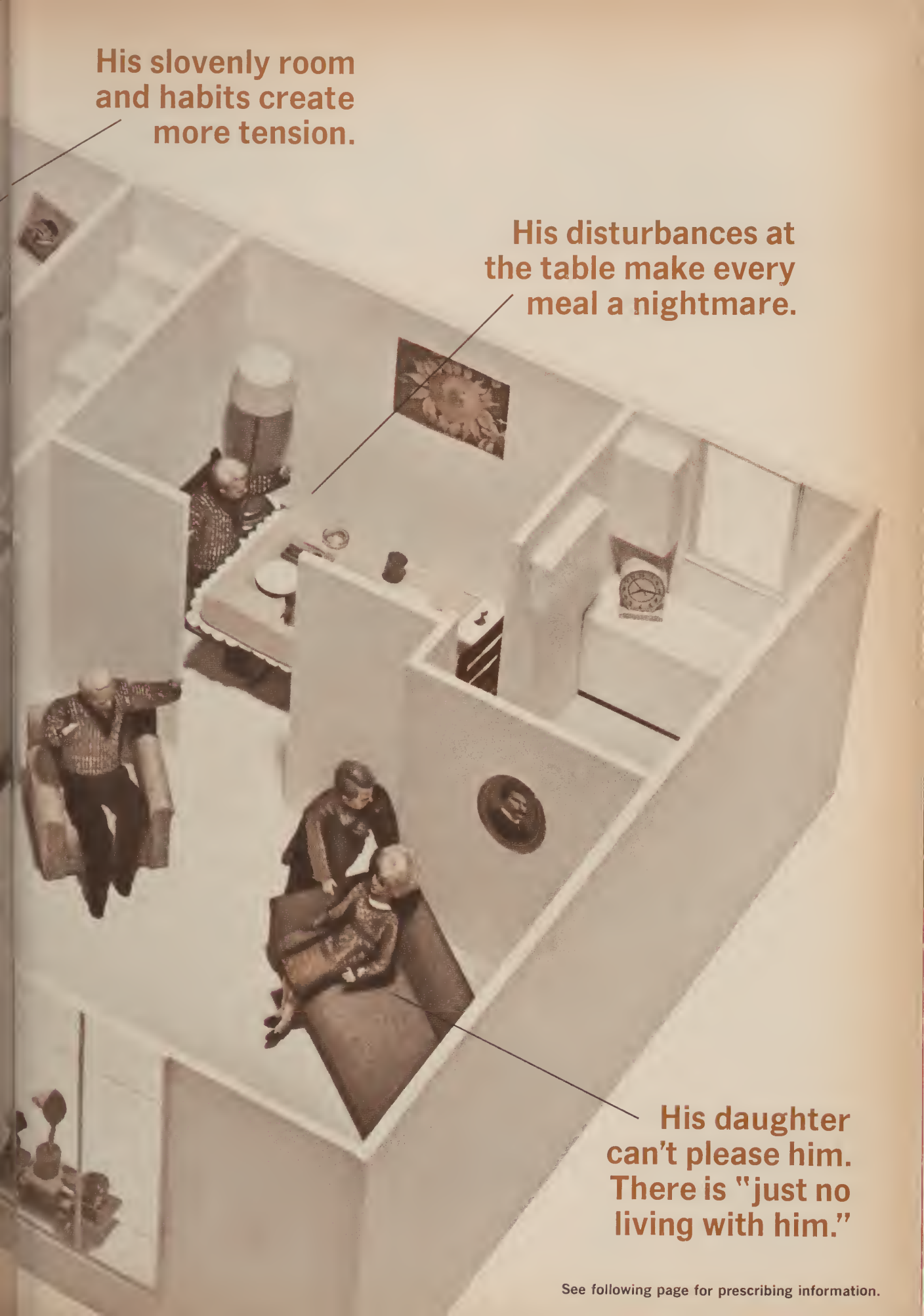
His teen-age granddaughter won't invite friends home because of his outbursts.



for moderate to severe anxiety

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When the agitated geriatric disrupts the home...

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Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

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Alcoholism SECTION

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

Getting Involved with Alcoholism in Medical Practice

JOHN H. HIRSCHFELD, MD
Presented at the 1966 Interim Scientific Session, Phi Lambda Kappa Medical Fraternity

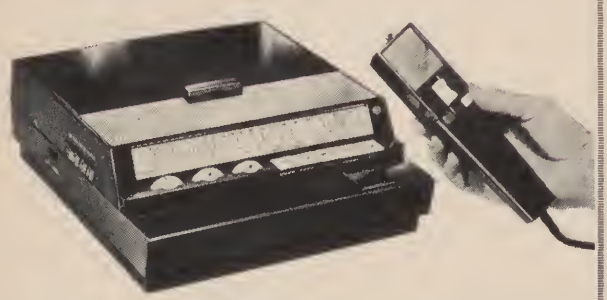
In November 1962, when as a member of the Committee of Public Health, Preventive Medicine and Postgraduate Education of the Maryland Medical Society I was asked to form and head a subcommittee on Alcoholism, little did I realize that some three years later I would be deeply involved with treating alcoholics. Apart from being on many committees and on the Third Task Force of the Mayor of Baltimore, I have this year been projected to the Presidency of the Baltimore Area Council on Alcoholism. These ever-increasing contacts with patients are causing my confreres to change my identity gradually from chest specialist to alcohologist.

First, a few cold statistics. There are at this time in the United States seven million alcoholics, a conservative estimate. This does not imply that there are seven million Skid Row alcoholics or Bowery bums. Only 3% of all alcoholics are in the Skid Row category. The remainder are distributed among all strata of the population—my patients and yours. It is infrequent that an alcoholic walks into the office readily admitting to alcoholism. The disease presents itself in rather devious ways. Frequently a patient seeks out help claiming to have "lost time from work because of a bad cold, or a stomach virus," and wants you to write him an excuse for his job after "having recovered." Or a patient on anticoagulants shows the craziest variation of his prothrombin level from week to week.

Others come to the office complaining of a multitude of pains, aches, or other symptoms, without ever responding satisfactorily to any symptomatic therapy. A housewife has unexplained palpitation and tachycardia. While her cardiogram shows signs of relative coronary insufficiency, therapy is singularly ineffective until four months later the young lady breaks down and tearfully relates that her minister advised her to tell me how worried she was about her husband who, working at an arduous job, returns home drunk night after night. Other instances occur, especially in women—housewives, middle-aged salesladies—who see you a few days after "an injury," or showing unexplained bruises. When you scold them for not having seen you earlier, they sweetly say that they did not want to bother the doctor in the middle of the night or over the weekend. Obviously, in their vanity these women do not want to have you see them while they are drunk.

Let us get a definition of alcoholism in order to understand the disease. There are several. Jackson Smith, MD, defined an alcoholic as an individual

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whose drinking causes him obvious difficulty physically, socially, or in his marriage or occupation, and who drinks more, to overcome this difficulty. The World Health Organization gives this definition: "Alcoholics are those excessive drinkers whose dependence upon alcohol has attained such a degree that it results in a noticeable mental disturbance, or in an interference with their bodily and mental health, their interpersonal relations, their smooth social and economic functioning, or those who show prodromal signs of such development."

Another definition is that the alcoholic is one who drinks more than you. Joking aside, the quantity does not necessarily have anything to do with it, although all alcoholics have at one time consumed ever larger quantities until their tolerance shrinks, and in the advanced stage a relatively few drinks will cause severe intoxication. Most alcoholics have, as I am told, certain psychologic traits. They are frequently depressed and almost always phobic. Phobic neurosis is the most common neurosis in metropolitan USA. For instance, this causes 30% of all women to be frigid, and 40% of all women to be afraid to drive downtown. Frequently, the passive dependent homosexual may resort to alcohol as an escape. (Not so frequently the aggressive male homosexual.)

This reminds me of a recent case brought to my office by a non-practicing or arrested alcoholic. She phoned me that an acquaintance of hers had called her desperately that she has been sexually attacked, and that she was all scratched up. Sensing a possible police case, I asked her who attacked her and found out that the attack had occurred in the course of a wild drinking spree in the apartment of a girl friend. While I was relieved that this, after all, was not a case involving the police, I saw and examined both women and could never find out who did the sexual attacking—except that both had been stone drunk, until one began to hallucinate, and accused the other of a lesbic advance and then began clawing her. Talking to these two confirmed alcoholics and examining them both took over two hours, way past lunch time. Everybody was hungry, so the ex-alcoholic who had brought them to me took these two souls out to a late lunch, consisting of spaghetti, meat balls, and I later found out, wine. (The ex-alcoholic, however, sat there without

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stopping the two drunks.) Later they again went to their apartment and got stone drunk on bourbon.

This brings me to the futility in dealing with many alcoholics. There is no rhyme or reason in what they do sometimes. There is a tendency to lie, to cover-up, and to live in a "make-believe world of their own" where doctors' bills, for instance, take care of themselves. Even the lack of judgment on the part of our ex-alcoholic Good Samaritan was a significant symptom.

We spoke of the phobic, but there are counter-phobic alcoholics—those indulging in heroic undertakings to overcome their unconscious phobia. Here is the he-man, who frequently needs alcohol to prepare him for his heroic physical or sexual undertakings.

During a history and physical of a patient in the office, one often can get clues of hidden alcoholism. For instance, there is the breakfast and lunch-skipper, whose stomach, perhaps because of the hangover, is intolerant of food at an early hour. One of our internists is particularly fond of giving a thorough ophthalmoscopic examination—not that there are any specific eye ground changes for alcoholism—but rather to discover the smell of alcohol at this range. Naturally, coarse tremors, nystagmus or history of unexplained convulsions in an adult may give a lead. In the hospital, sudden disorientation, hallucination or the "shakes" in a case of pneumonia, fracture, or after surgery for an acute abdomen, may painfully reveal a carefully concealed story of chronic alcoholism. We must suspect alcoholism in any patient who constantly requests tranquilizers or sleeping medication; who complains he can't eat breakfast; who uses strong-smelling mouthwash or excessive perfume; who has a tremor, unexplained rapid pulse, hoarse voice, venous distension on the face, spider angiomata of the chest or arms, unexplained bruises or cigarette burns.

A personal history may uncover clues:

1. The patient without a high school education. Fifty-five per cent of alcoholics drop out of school prior to graduation, showing signs of immaturity and impulsiveness, two characteristics of many alcoholics. So the school gadfly metamorphoses to a bar fly.
2. The man who changes jobs frequently. One-third of the patients in a large Alcoholism Clinic gave a history of having had more than

five jobs in the past ten years.

3. The man who holds a position well below his obvious education and ability.

4. The executive in a good position who takes an inferior job with a smaller company.

5. The self-employed man who goes into bankruptcy.

On prying deeper one usually finds out from the family that the man had a deep alcoholic problem.

6. The apparently, healthy man who is unemployed.

7. The patient who is not living with his wife.

Of great significance is the fact that two out of three alcoholics are not living with their wives, and, vice versa, the female alcoholic is frequently a middle-aged divorcee. Roughly half of all divorces of mature adults are thought to arise from the alcoholism of one or both partners.

The myth that some races of ethnic groups are immune from alcoholism has, by now, been destroyed. Given enough time, perpetuation of our social life pattern and prosperity, no one is safe from alcoholism.

Prohibition, as you know, is not the answer, since some of you will remember to what extent clandestine drinking and crime flourished. When in fact it was broken by several Canadian provinces going wet, the poem quoted here demonstrates prohibition's failure:

Four and twenty Yankees
Feeling mighty dry
Took a trip to Canada
And bought a case of rye.
When the case was opened
The Yanks began to sing,
"To Hell with the President.
God save the King."

On the other hand, communities must take a more serious view of this disease. The physician alone cannot solve this social illness. To use the general tax dollar to pay for comprehensive programs may seem logical and imperative for those who have been victimized or deprived of a loved one by a drunken driver, but preferably a heavier tax on alcoholic beverages, channeled into a special *Medical Alcoholism Fund,* would serve a dual purpose of curbing the overabundance of these products and pay for the treatment of their effect upon the human mind and body.

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*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: E. coli, Klebsiella, Aerobacter, Proteus, Paracolon or Pseudomonas[2]... However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.

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Pr utions: As with all new drugs, blood and liver function tests are advis-ab during prolonged treatment. **Pending further experience, like most ch otherapeutic agents, this drug should not be given in the first trimester of gnancy. It must be used cautiously in patients with liver disease** or **se e impairment of kidney function.** Because photosensitivity reactions have oc red in a small number of cases, patients should be cautioned to avoid un essary exposure to direct sunlight while receiving NegGram, and if a rea on occurs, therapy should be discontinued. The dosage recommended for ults and children should not arbitrarily be doubled unless under the car l supervision of a physician. Bacterial resistance may develop.

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Ref nces: (1) Based on 23 clinical papers, 1512 cases. Bibliography on requ t. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: Ant microbial Agents and Chemotherapy—1964, Ann Arbor, American Soc y for Microbiology, 1965, p. 722.

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Baltimore City Medical Care Services Survey

A household survey of medical care services and needs has been completed by the City Health Department's Medical Care Services Section. Begun early this year the survey's objectives were to measure the utilization of medical services by economically deprived inner city residents and to ascertain the extent of unmet needs. One thousand households were interviewed and a summary of the study is as follows:

1. Of the 1,000 households interviewed 515 or 51.5% had members reported to have Medical Assistance Program (*MAP*) identification cards.

2. Households with members on the Medical Assistance Program were significantly larger and younger than those not on the program. The median number of family members of households on *MAP* was 3.7 compared to 2.7 for households not on *MAP*. The average age in *MAP* households was 25 years compared to 39 years for households not on *MAP*.

3. Individuals on the Medical Assistance Program reported a significantly higher incidence of illness than those not on *MAP*.

4. Of those individuals who said they suffered an illness, 38.8% went to a private physician compared to 56.2% who went to a clinic or outpatient facility; 5% went to both. In this regard it is of interest to note that studies of the City's medical care program, prior to its expansion through Title 19 funds, show that more services were received from private physicians than through the now discontinued medical care clinics at seven contract hospitals. As soon as data are made available, assessments of services under the Medical Assistance Program will determine whether an actual shift in the provision of medical services has occurred.

5. Illness among all individuals was reported most frequently for those aged 65 and over. For those on *MAP*, illness was more frequent in the 45-64 age group.

6. Females in the age group 45-64 predominately utilize private physician services; in contrast males 45-64 went to outpatient facilities.

7. For those who had not visited a doctor during the two weeks prior to the interview, the median length of time since their last check-up by a physician was 5.5 months for those on *MAP* and 7.7 months for those not on *MAP*.

8. No significant difference was noted in the percentage of children having check-ups by a physician whether on *MAP* or not (36% vs. 33%). Of 1,392 children in *MAP* households, 496 had check-ups during the year prior to the interview; this is compared with 759 children not on *MAP* of whom 254 had check-ups.

9. Unmet needs—in 88 households someone needed a hearing aid, a component part, or repairs. Other artificial appliances needed included artificial eyes, 5, artificial arms, 2 and artificial legs, 2. Of 461 individuals who were said to need eyeglasses 315 were in households on the *MAP*. Over 100 of those in need of

eyeglasses were children under 21 years of age.

This Medical Care Services household survey report is one of a continuing series of studies of the city's medical care needs conducted under the supervision of Martin K. Gorten, MD, Assistant Commissioner of Health for Medical Care. Mrs. Helen B. Freedman, senior public health analyst, analyzed and assembled the material, and Henry W. D. Holljes, MD, and Matthew Tayback, MD, served as consultants.

According to the Maryland State Department of Health, the administrative agency of the Maryland Medical Assistance Program of which Baltimore's program is now a part, at least 16% of Baltimore City's population is on the Medical Assistance Program eligibility rolls.

Robert E. Farber, M.D.
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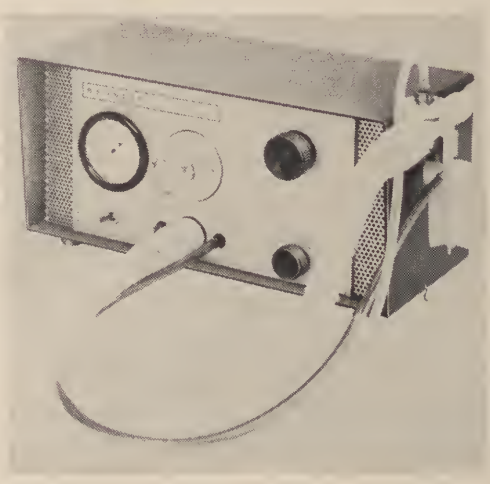
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REHABILITATION Notes

REHABILITATION SECTION
BALTIMORE CITY MEDICAL SOCIETY,

DOUGLAS G. CARROLL M.D.
EDITOR

Cardiac Rehabilitation

THE ACUTE STAGE. PSYCHOLOGICAL FACTORS IMPORTANT IN REHABILITATION

DOUGLAS CARROLL, MD
Chief, Physical Medicine and Rehabilitation
Baltimore City Hospitals

It is the purpose of these notes to draw attention to some important features of cardiac rehabilitation. There will be no attempt to cover medical or pharmacological features of therapy. Psychological matters are given particular emphasis for three reasons. They are of major importance in good medical management; they may be the only aspect of the illness subject to prevention and/or modification by treatment; they are frequently neglected.

Cardiac Rehabilitation

Cardiac rehabilitation starts the hour the diagnosis of heart disease is made. The initial reaction of the physician, the way he breaks the news to the patient and family and the direction he gives in regard to exertion may have a profound effect on the patient's interpretation of the meaning of his illness. The physician's interpretation of the meaning of heart disease to the patient is important no matter how acute or chronic the expected course of the disease. The following discussion, however, will be concerned mainly with acute myocardial infarction.

Early Psychological Reactions to Acute Myocardial Infraction:

1. The Patient:

Olin and Hackett[1] have pointed out a curious finding in a number of patients who had suffered a typical myocardial infarction. Although most of their 32 patients were familiar with the symptoms of coronary artery disease, their immediate reaction to the development of chest pain was to attribute it to less threatening diseases than myocardial infarction. None of these patients suffered from fright and anxiety. Indeed their reaction was that "It couldn't happen to me."

We have been convinced that this denial reaction is not unusual in acute myocardial infarction. It occurs in young men who are "on the make" financially and whose whole fabric of economic security stands to collapse if they cannot continue their activities. Although denial is essentially an emergency defense against anxiety, it may persist into the convalescent period following myocardial infarction and may interfere with a sensible follow-up. In short, these patients try to take medical matters into their own hands; they follow directions poorly, may leave the hospital too soon and do not return for follow-up. Identification of this personality pattern early may allow the physician to manage the patient with greater ease.

A far less common emotional pattern is seen in the patient whose infarction is the answer to a major life problem. It may present the excuse he has been looking for to withdraw from a job

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which is too much for him. It is my impression that this reaction of invalidism is less common following myocardial infarction than it is following industrial injuries, at least in the younger age group of patients with myocardial infarction.

2. The Family:

Hackett[2] has reported two types of reaction to the patient's illness on the part of families: a guilt-manipulation cycle and the alienation syndrome. In the former the family feels guilty about the patient's illness and allows itself to be manipulated by the patient. This reaction, in my experience, is particularly seen in the family of the hard working, devoted-to-business executive, who is generally believed to have been working too hard.

The alienation syndrome is the withdrawal of the family from the patient under the pressure of illness. This reaction of the family is unusual in patients with acute myocardial infarction; more often the heart attack may serve to bring the family together.

3. The Physician:

Iatrogenic heart disease[3] is "used chiefly of imagined ailments induced in a patient by autosuggestion based on a physician's words or actions during examination."[4] Generally the term is used to apply to patients who have no heart disease, but it can just as well be used to describe those physician—induced symptoms arising purely from anxiety in patients who actually have some type of heart disease. In general, iatrogenic symptoms arise only in patients who have an underlying anxiety. The physician merely sows seeds of anxiety in the fertile psychological soil of an anxious patient. Furthermore, it is my impression that these symptoms arise most frequently when the physician is uncertain of the diagnosis or mode of therapy and rarely where the diagnosis is clearly established and treatment standardized. In any case, it is important for the physician to be conscious that his every action and word may be misinterpreted by an emotionally unstable patient.[5] Thus, explanation of the nature of the disease to the patient must be a dialogue; the physician must be sure the patient understands what is said and is involved in treatment decisions. He must be allowed to express fears and to ask questions.

Reassurance is important early in acute myocardial infarction. Optimism as to the final outcome is justified since the majority of patients with acute myocardial infarction are able to return to their pre-infarction occupation.[6]

4. Social Psychology of acute myocardial infarction:

Of all the major diseases, myocardial infarction is the most acceptable socially. In some cultures it is looked on as a badge of good conduct and hard work.[2] Those who are able to leave the hospital appear normal, are able to do at least light activity and have no necessary mental deficit. There is no obvious deformity. All the other major diseases—cerebrovascular accident, cancer and arthritis have a poor prognosis, result in mental deterioration, the possibility of surgical mutilation or obvious impairment.

Summary

The meaning of an acute myocardial infarct to the patient and his family may turn out to be of overriding importance to rehabilitation.

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Diagnostic Procedures Recommended in the Care of Prenatal Patients Exposed to Rubella or Presenting Rubella-Like Symptoms

If a woman in the first trimester of pregnancy develops a rubella (German measles) infection either clinical or inapparent, there is a considerable risk that her child may be born with serious physical defects. Rubella infection in the second trimester also carries a risk but to a lesser degree. Once such maternal infection occurs, nothing can be done to prevent infection of the fetus with possible congenital rubella sequelae. Some authorities recommend interruption of pregnancy up to 14 weeks gestation in prenatal cases with confirmed rubella.

There are available laboratory examinations which may aid the physician in choosing a course of treatment when his prenatal patient presents with suspicious signs and symptoms of rubella or gives a history of exposure to a case of the disease. These tests, if timely done, can determine if the recent exposure has induced rubella infection or if the patient is immune from a previous infection. History of prior rubella is practically worthless in the absence of laboratory confirmation of the diagnosis.

PROCEDURE

Collection of Specimens

1. Laboratory serologic tests on two blood specimens taken at different times are necessary.

a) The first specimen must be collected as soon as possible after exposure or after the patient has shown symptoms suspicious of rubella, preferably within 2 or 3 days.

b) The second specimen should be collected 14-21 days after the first.

2. Seven or 8 ml. of blood are drawn in the usual sterile blood tube and either the serum or the whole blood without preservative sent promptly to the Bureau of Laboratories, 16 E. 23rd Street, Baltimore 21218. DO NOT FREEZE.

3. Each specimen must be accompanied by a laboratory request slip which includes:

a) Physician's name and address
b) Test desired
c) Patient's name, age, and address
d) Estimated week of pregnancy
e) Date of onset of recent rubella-like illness, if any
f) Date of exposure to a case of rubella

Items d, e, and f are useful to the laboratory in selecting suitable tests.

4. The laboratory will report the rubella antibody titre found on the HI (*hemagglutination inhibition*) test and/or the CF (*complement fixation*) test when indicated.

5. A report of the HI test on the first specimen, although not conclusive, will be sent to the physician as soon as possible in order to permit any indicated procedure.

Interpretation of Laboratory Results and Suggested Care of the Patient

A. If the HI titre of the first blood is less than 1:8 ($<$1:8), the result is to be interpreted as an absence of rubella antibodies. It is evident that the woman has no protection against rubella. One of two courses may be followed by the physician:

1. He can wait 14 to 21 days and take a second specimen of blood.

a) If the HI titre of the second blood remains less than 1:8 ($<$1:8), the suspected exposure has not resulted in rubella infection and/or the rubella-like illness was not rubella.

b) If the HI titre of the second blood is greater than 1:8 ($>$1:8), this is evidence of active rubella infection and nothing can be done to prevent possible congenital rubella in the fetus.

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Recently Modell[2] has stated: "The mercurial diuretics are the injectable diuretics of choice since they are the most potent as well as the most dependable. Their toxicity is not an important consideration either by comparison with other potent diuretics or in relation to the seriousness of the conditions in which they provide such excellent relief."

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1. Gold, Harry, *et al.: A System for the Routine Treatment of the Failing Heart,* The American Journal of Medicine, Vol. III, No. 6:665-692 (Dec.) 1956.

2. Modell, Walter: *Drugs of Choice 1966-1967,* p. 97, 1966.

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2. Gamma globulin (20-25 ml.) I M may be tried as a prophylactic provided it is given within 7 days of exposure. The effectiveness of gamma globulin in preventing congenital rubella is not known; it may merely serve to mask clinical evidence of infection. A second blood should be examined 21 days after gamma globulin is given to detect possible rubella infection. If the second blood shows a four-fold rise in either HI or CF titres, this is proof that infection has taken place. In this situation nothing can be done to prevent congenital rubella.

B. If the HI titre of the first blood is 1:8 or greater, this is evidence of rubella infection before the blood was drawn. It is possible that this infection was still active at the time the blood was drawn. A second blood specimen should be taken 14 to 21 days after the first and both specimens (*paired sera*) examined simultaneously for HI and CF antibodies.

1. If the second specimen shows no significant rise (four-fold or more) in either HI or CF antibody titres, this is evidence that the rubella infection was probably terminated before the first blood was drawn. If the HI titre is very high (1:1024 or greater), it is likely that the infection was recent. A clinical history though not always dependable may help to determine if such infection occurred during pregnancy.

2. If the second blood shows a four-fold or greater rise in HI or CF titres, this is evidence of infection which was active when the first blood was drawn. Nothing can be done to prevent possible fetal damage from rubella.

CONCLUSION

Until such time as a dependable vaccine against rubella becomes available, the prevention of congenital rubella depends upon the dubious effectiveness of gamma globulin or the interruption of pregnancy. Neither of these procedures should be instituted until the immunity status of the patient is determined by carrying out the rubella serology suggested above.

NOTE: The Bureau of Laboratories is now running routine rubella HI tests on all prenatal bloods tested for STS and Rh. This should become standard procedure in prenatal care.

These recommendations have been drawn up by the Division of Communicable Diseases and the Division of Virology of the Maryland State Department of Health with the assistance of Doctors Joseph A. Bell, Janet M. B. Hardy, Ernest H. Joy, and John L. Sever.

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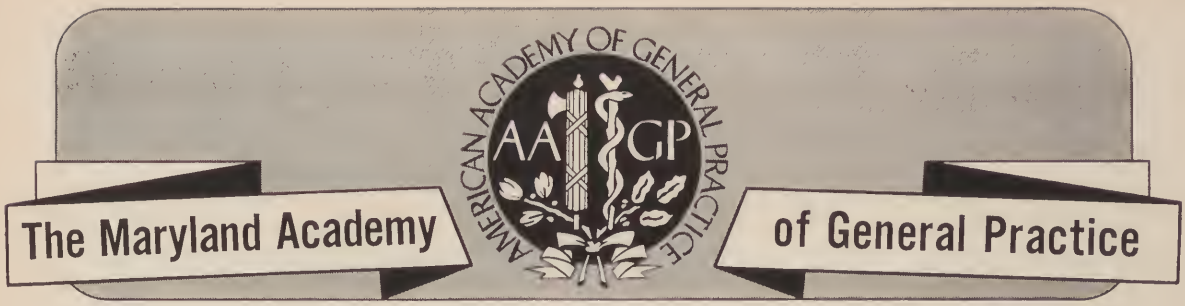
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A proposed amendment calling for changing the Academy's name was considered by the Congress of Delegates of the *AAGP* in Dallas at the Academy's Annual Convention held Sept. 16-21, 1967. The amendment calling for a new name, "American Academy of Family Physician" was proposed at the direction of the 1966 Congress of Delegates with the futher request that delegates poll their chapters for the opinion of the membership on the change and be prepared to consider it at the 1968 Congress.

The vote of 58 for and 45 against the new name was not a sufficient majority to effect the change. A two-thirds majority is required to amend the Academy's Constitution. We, in the state of Maryland voted *two to one* for the change.

It was the consensus of opinion that the American Academy of General Practice was founded for specific objects and purposes which are set forth in the Constitution of the organization; and that its present name embodies the purpose and language of those objects.

Though reluctant to remove the term "General Practice" from the official name of the Academy, the delegates at the Annual Convention did approve steps taken to establish the new "American Board of Family Practice," and did endorse the new name for the proposed primary physicians' board.

G. OVERTON HIMMELWRIGHT, MD
Past President, Maryland Academy of General Practice

A survey of the entire American Academy of General Practice revealed that almost 10,000 (74.1%) of those responding desire to participate in the tests for certification. Eight thousand of these indicated they would be ready to take the examinations in July, 1968.

The Commission on Education, however, has notified the state chapters that refresher courses could not properly be set up before the first examination in July, 1968. The Subcommittee on Postgraduate Education, however, will provide specific study suggestion for interested 1968 candidates.

The Certification Test Committee has informed the state chapters that the proposed examination would last two days. The first day would consist of multiple choice questions; the second day, of programmed testing and filmed questions. Clinical divisions and basic sciences will be coordinated within the whole test, instead of being separate entities. There will be no oral examination.

Standards for this new specialty and requirements for qualifications of applicants were outlined in the August 1967 issue of this Journal.

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NOVEMBER 1967 MRS. HARRY L. BERMAN, Editor

SEMIANNUAL MEETING

Seventy-five women gathered at the Diplomat Motor Hotel in Ocean City, Maryland, on Friday morning, September 8, 1967, for the Semiannual Meeting of the Woman's Auxiliary held concurrently with the semiannual meeting of the Medical & Chirurgical Faculty.

Previous to the business meeting, buns and coffee were served under the direction of the hospitality chairman, Mrs. Richard D. Bauer, who engendered a cheerful and enthusiastic atmosphere which prevailed throughout the entire meeting.

Mrs. William S. Stone, president of the Auxiliary, presided over the meeting, which was opened by a prayer and the pledge of allegiance. Dr. Robert B. Goldstein, Medical & Chirurgical Faculty Advisor to the Auxiliary and chairman of the Med-Chi Public Relations Committee, brought greetings to the doctors' wives.

Doctor Joseph H. Hooper, Jr., Chairman of the Executive Committee of the Maryland Medical Political Action Committee, spoke to the assembly on the importance of their participation as doctors' wives in politics as it affects medicine.

Among the business transacted at the meeting, was the election of the following members to the nominating committee: Mrs. Percy H. Sutley of Lutherville, chairman; Mrs. Archie R. Cohen, Clear Spring; Mrs. A. Austin Pearre of Frederick; Mrs. Frank E. Poole, Salisbury; and Mrs. John G. Ball of Bethesda. Preliminary plans were announced for an AMA Education and Research Foundation benefit at the Morris Mechanic Theatre in Baltimore on Wednesday evening, April 17, 1968.

Highlight of the meeting was the program arranged by Mrs. Carlton Brinsfield, program chairman. Guest speaker, Dr. Maxwell N. Weisman, Director of Community Psychiatric Services, State Department of Mental Hygiene, Maryland, found a deeply interested audience in his topic, "Is Your Teen-Ager Dependent on Alcohol and Drugs?"

Delegates to the semiannual meeting were: Mrs. Robert Kimberly and Mrs. Ferdinand Kadan of Baltimore City, Mrs. Raymond Cunningham and Mrs. Elliott C. Flick of Baltimore County, Mrs. Edgar E. Folk III and Mrs. I. Randall Ross of Cecil County, Mrs. Wallace H. Sadowsky and Mrs. H. Proctor Sidwell of Harford County, Mrs. L. Louis Mould and Mrs. G. Allen Moulton of Allegany County, Mrs. Fred Musser and Mrs. Jack Sugar of Prince George County, Mrs. John Robben and Mrs. John Lertora of Montgomery County, Mrs. Daniel Sprecher and Mrs. Thomas Craig of Washington County; Mrs. Vincent O. Eareckson and Mrs. Louis Welty of the Four-County Auxiliary (Caroline, Kent, Queen Anne and Talbot); Mrs. E. Kent Carney and Mrs. William Campbell of Wicomico County; and Mrs. Thomas F. Herbert and Mrs. Albert Cooper Members-at-Large.

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Meetings November-December

PATHOLOGY SECTION

Edward L. Sherrer, M.D., *Chairman*
William J. Hicken, M.D., *Secretary*

Monday, November 20, 1967, 8:00 p.m.

Program to be announced.

MARYLAND DERMATOLOGICAL SOCIETY

Raymond C. Vail Robinson, M.D., *President*
Herbert L. Kronthal, M.D., *Secretary*

Monday, November 27, 1967

Penn Hotel, Towson, Maryland, 6:30 p.m.

Endocrinology and Dermatology. JOHN G. WISWELL, M.D., Associate Professor, Department of Medicine, University Hospital.

ANESTHESIA STUDY COMMITTEE

Joint Anesthesia Study Committee of the Baltimore City Medical Society and the Baltimore City Health Department.

Tuesday, November 28, 1967, 7:30 p.m.

COMING MEETINGS DECEMBER, 1967 BALTIMORE CITY MEDICAL SOCIETY

ANNUAL BUSINESS MEETING

Friday, December 1, 1967, 7:30 p.m.

Report of officers and committees. Election of Officers, Delegates, Alternate Delegates, Members of the Nominating Committee for 1968, and Presidential Address.

SOCIAL HOUR, 9:00 P.M.

The doctors are cordially invited by the Woman's Auxiliary to the Baltimore City Medical Society to join them for refreshments and entertainment following the meeting of the Society.

WOMAN'S AUXILIARY TO THE BALTIMORE CITY MEDICAL SOCIETY

Friday, December 1, 1967

Business Meeting—8:00 p.m.

Joint Social Hour for Members and Husbands—9:00 p.m.

All meetings will be held at 1211 Cathedral Street, Baltimore, Maryland 21201, unless otherwise stated.

NOVEMBER 17—12:30 P.M.

Poisoning and Poison Control

Gina M. Glick, MD, Poison Control Officer, Sacred Heart Hospital
Elizabeth G. Brings, MD, Pediatrician, Cumberland

Sponsor: Sacred Heart Hospital

NOVEMBER 24—1:00 P.M.

Cardiac Failure in Infancy and Childhood

Catherine A. Neill, MD, Associate Professor of Pediatrics, The Johns Hopkins University School of Medicine

Sponsor: Frederick Memorial Hospital

DECEMBER 1—12:30 P.M.

Coronary Care Unit—Purpose and Management

Kenneth B. Lewis, MD, Chief of Cardiovascular Division, Baltimore City Hospitals

Sponsor: Baltimore City Hospitals

DECEMBER 8—12:30 P.M.

Diagnostic Problem
Panel Discussion

Moderator: Thaddeus E. Prout, MD, Chief of Medicine, Greater Baltimore Medical Center

Sponsor: Greater Baltimore Medical Center

DECEMBER 15—12:30 P.M.

Unmasking Malignancies of the Ear, Nose, and Throat

Jerrie Cherry, MD, Assistant Professor of Surgery, Laryngology, and Otolaryngology, The Johns Hopkins University School of Medicine

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Vol. 16, No. 12
December, 1967

TRANSACTIONS

Maryland STATE MEDICAL JOURNAL

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DATE: DEC 67
DEPTH:
NON-DEPTH: X
RUSH:
SELECTIVE:



OFFICIAL PUBLICATION OF THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

Dilantin®
(diphenylhydantoin)

PARKE-DAVIS

In untold thousands of epileptic patients... Dilantin has been, and continues to be, the bedrock of therapy.

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DILANTIN is supplied in several forms including Kapseals® containing 0.1 Gm. and 0.03 Gm. diphenylhydantoin sodium.
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Diet Control — **Appetite Control**

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Not marketed in combination with any anorexiant drug, since that would limit the dosage flexibility of both.



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Maryland
STATE MEDICAL JOURNAL

In This Issue...

Vol. 16, No. 12
December, 1967

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Doctors take note...

NATIONAL FOUNDATION MARCH OF DIMES

January 10

Sympasium an Intrauterine Infections—spansared by New Yark Chapter at the Americana Hatel, 7th Ave. at 52nd St. New York City. Cantact Executive Director, New Yark Chapter, the Natianal Foundatian—March af Dimes, 315 Park Avenue South, New York, N. Y. 10010.

AMA COMMITTEE ON MATERNAL AND CHILD CARE

January 11-13, 1968

First Internatianal Canference an Prematurity—Pier 66, Fart Lauderdale, Flarida. Cantact Wesley J. Duiker, Secretary, Cammittee an Maternal and Child Care, American Medical Assaciatian, 535 North Dearborn St., Chicago, Ill. 60610.

PHI DELTA EPSILON FRATERNITY

January 16

23rd Annual Lectureship of the Phi Delta Epsilan—11:30 a.m. Gardan Wilsan Hall, University Haspital. Abraham I. Braude MD Professor af Medicine University of Pittsburg Schaol af Medicine. Far infarmatian call 727-7077.

AMERICAN RHEUMATISM ASSOCIATION

January 19-20, 1968

13th Interim Scientific Sessian—To be held at Sheratan-Belvedere Hotel, Baltimare. Fifty papers will be presented an recent developments. Contact Miss Margaret M. Walsh, 1212 Avenue of the Americas, New York N. Y. 10036.

AMERICAN REHABILITATION FOUNDATION

January 9-20, 1958

Two day course—New Cancepts in Problems of Completed Stroke—16 haurs prescribed credit ta American Academy of General Practice. Cantact Thomas P. Andersan, MD, 1800 Chicago Avenue, Minneapolis, Minnesata. 55404.

MARYLAND ACADEMY OF OPHTHALMOLOGISTS

January 24, 1968

Meeting—Speaker, Alston Callahan, MD, an Surgical Advances in Ophthalmalagy at Kennedy Warren Hotel, Washington, D. C. Cantact Leanard L. Kagan, MD, 1106 Spring Street, Silver Spring, Md. 20910.

PHILADELPHIA COUNTY MEDICAL SOCIETY

Febuary 20-23

32nd Annual Pastgraduate Institute af the Philadelphia Caunty Medical Society will be held at Bellevue-Stratfard Hatel. Cantact Rabert L. Mayack, MD, 2100 Spring Garden St., Philadelphia, Penna. 19130.

SEMINAR FOR PHYSICIANS ON TREATMENT OF ALCOHOLISM

March 7

Maunt Wilsan State Haspital—10 a.m. to 3 p.m.—Speakers: Ruth Fax, MD Medical Direcar Natianal Cauncil an Alcahalism, Inc., Marvin Black, MD, Farmer Chairman Cammittee an Alcahalism, AMA. Spansared by Subcammittee an Alcahalism af the Medical and Chirurgical Faculty and State Department af Mental Hygiene.

New Publications

Widespread concern, particularly among alarmed parents, over the nation's rising drug abuse problem and the raging "front-page" controversy centered around the increasing use of *LSD,* marihuana and other hallucinogenic drugs by thrill, curiosity and "self-improvement" seekers on and off college campuses has spurred the *AMA* to develop a 25-page booklet, *The Crutch That Cripples: Drug Dependence.*

The publication is designed to give the public a sound understanding of drugs, their uses and abuses and the problems which irresponsible use leaves in its wake.

The publication was prepared by the Committee on Alcoholism and Drug Dependence, Council on Mental Health, in response to heavy mail and telephone inquiries received in recent months by the *AMA's* Department of Mental Health.

Written lucidly and in colorful language readily understood either by parents or the younger set, *The Crutch That Cripples,* discusses all aspects of drug use.

Among the topics covered are medical uses of drugs, drug dependence, drug abusers, abuse of narcotics, sedatives, stimulants and hallucinogens, where to get help for drug abusers and prevention of abuse. The booklet also calls attention to a current bibliography available from the Department of Mental Health on drug abuse and drug dependence.

Copies of the publication may be obtained from the *AMA* Order Department.

* * * * *

The third revision of *Group Practice: Guidelines to Forming or Joining a Medical Group,* originally published in 1962, is now off the presses. Medical societies and individual physicians may obtain complimentary copies by writing the Department of Health Care Services, *AMA.*

Jointly produced by the *AMA,* the American Association of Medical Clinics and the Medical Group Management Association, the 40-page booklet covers all aspects of group practice.

* * * * *

A new film depicting the wide range of rewarding career opportunities existing in fields allied to medicine, long sought by auxiliaries and others concerned with health careers programming, will be available for bookings after December 1.

The 28-minute color film, entitled *Horizons Unlimited,* after the *AMA's* health careers handbook of the same name, gives brief on-the-job glimpses of men and women serving in career pursuits highlighted in the publication. To give viewers greater insight as to the length of preparation and particular scope of specific professions and occupations, "thought voices" are utilized in some segments of the film.

The University of Kansas Medical Center, Kansas City, served as the setting for the film, which will replace the time-dated film, *Helping Hands For Julie,* developed by the *AMA* in cooperation with E. R. Squibb & Sons, in 1959.

The new film was developed solely by the *AMA.* Physicians, medical societies and other medical groups should place their orders for showings, stating preferred and alternate dates, with the Films Section, *AMA,* 535 North Dearborn, Chicago, Illinois 60610. Schools and other non-medical groups should direct their requests for loan of the film to Modern Talking Pictures, Prudential Plaza, Chicago, Illinois, 60601.

* * * * *

Having been deluged in recent months with irate complaints from physicians charging that those physicians who lend the use of their names for testimonial advertisements, many of which contain prominent photographs of the physician, are "prostituting the profession," the *AMA's* Judicial Council has reiterated its opinion providing a guideline for physicians in their relation to commercial enterprises.

In rendering its opinion the Judicial Council considered only the advertisements in question. It did not assess the conduct of the physicians involved because 1 no charges had been brought against any physician as an individual and 2 the Council refused to impute improper motives to any of the physicians who, it felt, acted without any intent to violate ethical standards.

The Council concluded, however, that is was imperative to warn physicians of the consequences of providing testimonials without fully consider-



Diagnosis:

cystitis?
pyelonephritis?
pyelitis?
urethritis?
prostatitis?

in any case,
usually gram-negative*

Therapy:

two 500 mg. Caplets® q.i.d.
(initial adult dose)

ions: Urinary tract infections caused by gram-negative and some gram- organisms.

ects: Mainly mild, transient gastrointestinal disturbances; in nal instances, drowsiness, fatigue, pruritus, rash, urticaria, mild hilia, reversible subjective visual disturbances (overbrightness of change in visual color perception, difficulty in focusing, decrease in cuity and double vision), and reversible photosensitivity reactions. overdosage, coupled with certain predisposing factors, has produced nvulsions in a few patients.

ions: As with all new drugs, blood and liver function tests are advis- ring prolonged treatment. **Pending further experience, like most herapeutic agents, this drug should not be given in the first trimester nancy. It must be used cautiously in patients with liver disease or mpairment of kidney function.** Because photosensitivity reactions have d in a small number of cases, patients should be cautioned to avoid sary exposure to direct sunlight while receiving NegGram, and if a occurs, therapy should be discontinued. The dosage recommended ts and children should not arbitrarily be doubled unless under the supervision of a physician. Bacterial resistance may develop.

sting the urine for glucose in patients receiving NegGram, Clinistix® Strips or Tes-Tape® should be used since other reagents give a sitive reaction.

Adults: Four Gm. daily by mouth (2 Caplets® of 500 mg. four times r one to two weeks. Thereafter, if prolonged treatment is indicated, age may be reduced to two Gm. daily. Children may be given nately *25 mg. per pound* of body weight per day, administered in doses. The dosage recommended above for adults and children ot arbitrarily be doubled unless under the careful supervision of a n. Until further experience is gained, infants under 1 month ot be treated with the drug.

pplied: Buff-colored, scored Caplets® of **500 mg. for adults,** conve- available in bottles of 56 (sufficient for one full week of therapy) and in f 1000. **250 mg. for children,** available in bottles of 56 and 1000.

ces: (1) Based on 23 clinical papers, 1512 cases. Bibliography on (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: robial Agents and Chemotherapy—1964, Ann Arbor, American for Microbiology, 1965, p. 722.

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rop Laboratories, New York, N. Y. 10016

NegGram®

Brand of

nalidixic acid

a specific anti-gram-negative

eradicates most urinary tract infections...

- Low incidence of untoward effects; no fungal overgrowth, crystalluria, ototoxic or nephrotoxic effects have been observed.

- "Excellent" or "good" response reported *in more than 2 out of 3* patients with either chronic or acute gram-negative infections.[1]

*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: E. coli, Klebsiella, Aerobacter, Proteus, Paracolon or Pseudomonas[2]... However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.

ing their potential impact upon the profession.

The complaints have stemmed from a rash of recent newspaper, Sunday supplement and magazine advertisements and also sensationalized "book jacket" copy prepared by publishers of books written by physicians.

Here is the opinion rendered by the Judicial Council:

"It is demeaning to the medical profession for a physician to permit the use of his name and professional status in the promotion of commercial enterprises. A physician may freely engage in business ventures outside the practice of medicine. However, out of respect for his profession, he should not allow his name or the prestige of his professional status as a physician to be used in the promotion of commercial enterprises."

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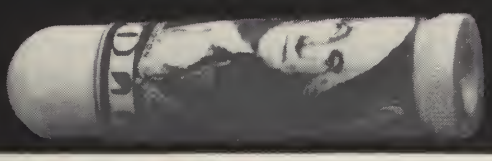
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where being FIRST makes all the difference.

For further information on this special low-rate Professional Loan: in Baltimore, call SA 7-4000, and ask for Mr. Jack Ortt or Mr. Dave Freese; in Hagerstown, RE 3-6000, Mr. Frank McConell or Mr. Bob La Follette; in Rockville, PO 2-8800, Mr. Walter Clark or Mr. Ray Greenstreet; in Salisbury, PI 2-8143, Mr. Ross Waterman or Mr. Ted Crockett. Or ask any branch manager.

MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND
1211 Cathedral Street, Baltimore 1, Maryland
(Adopted by the Council, September 7, 1967)

RECOMMENDATION OF THE AD HOC COMMITTEE TO STUDY THE ABORTION LAW

We believe the current law should be changed and updated for the following reasons:

(1) Because the current law should recognize advances in medical knowledge, and it does not. For example, the medical sciences of psychiatry and genetics were unknown at the time the bill was written.

(2) Because the law should contain safeguards to patients and the community which are presently absent. For example, a therapeutic abortion can now be performed in a home or in a physician's office within the present law.

(3) Because the law should permit a physician to exercise his own best *medical* judgment in the best interest of each of his patients.

It is true that within the medical profession there is a whole spectrum of opinion ranging from those who never perform a therapeutic abortion because of religious belief, to the other extreme, those equally conscientious physicians, who believe that all women should be masters of their own reproductive capacity, and that the interruption of an unwanted pregnancy should be solely an individual matter between the patient and her doctor.

However, this proposed change in the law, which we believe to be representative of the opinion of physicians in Maryland, recommends none of those positions which are based on social, economic, or religious grounds. Rather, our recommendations are designed to permit ethical physicians the right to exercise their *own sound medical* judgment relative to therapeutic abortion as in any other medical decision. We recognize that the granting of a license to a physician to practice medicine by the State of Maryland does not grant to that physician the right to decide for himself, based solely on his own personal and social judgments, whether to obey or disobey any existing law. We are pleading for a change in the law that will permit a licensed physician under circumstances prescribed by law to exercise his considered medical judgment in the light of current medical, scientific knowledge.

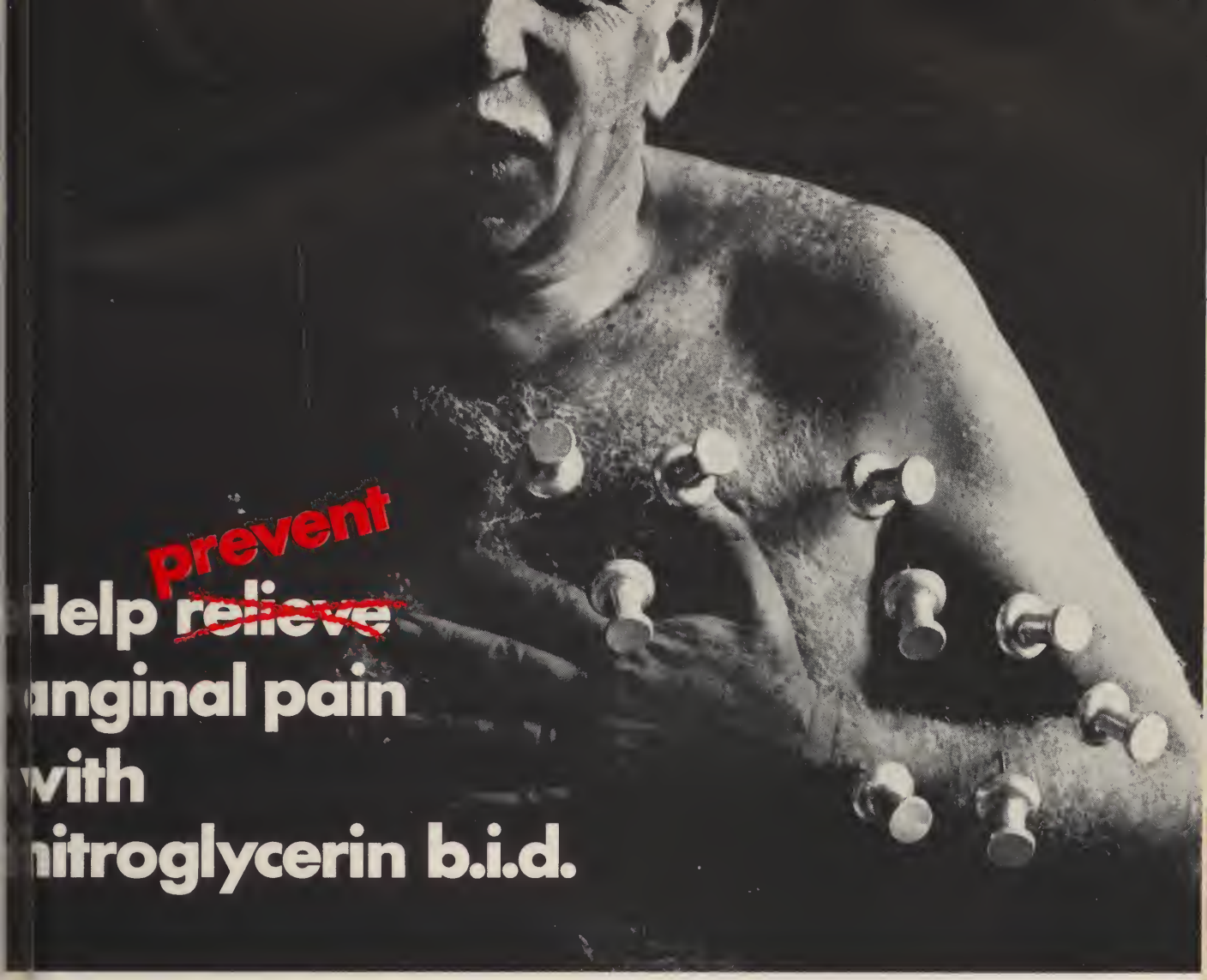
We recommend the following change in Section 3 of Article 27 of the Annotated Code of Maryland to change the grounds under which a physician may lawfully cause the abortion of a pregnant woman: starting on line 35, ". . . after consulting with one or more physicians, chosen because of their recognized professional competence, who have examined the patient and have concurred in writing that continuance of the pregnancy threatens the mental or physical health of the mother; or that the infant may be born with incapacitating physical deformity or mental deficiency; or that continuance of a pregnancy resulting from legally established statutory or forcible rape or incest threatens the mental or physical health of the patient; and the procedure must be performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals."

Finally, in the event that these proposals are made into law, the Medical and Chirurgical Faculty of the State of Maryland should provide guidelines to its members for appropriate practices in these respects. These guidelines could serve as criteria to be used by both the Joint Commission on Accreditation of Hospitals and the State Health Department. The interlocking effort of the American Hospital Association and the American Medical Association working through the Joint Commission on Accreditation of Hospitals, the Medical and Chirurgical Faculty of the State of Maryland and the Maryland State Department of Health, could and would prevent any misinterpretation of the intent of the law.

JOSEPH SEITCHICK, MD, *Chairman*

Ad Hoc Committee to Study the Abortion Law

J. TYLER BAKER, MD
JOHN M. HAWS, MD
EDMUND B. MIDDLETON, MD
JOHN W. C. JOHNSON, MD, Consultant

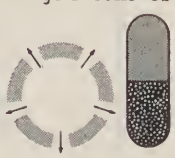


Unique Nitrospan micro-dialysis process* adds an important dimension–TIME–to nitroglycerin therapy

elps decrease frequency and severity of attacks; often creases exercise tolerance. Decreases need for sub-ıgual nitroglycerin, increases patient confidence. nooth, continuous release independent of gastrointes-ıal functions reduces headache and other side effects at might result from peak concentrations of tablet or termittent-release preparations.

dication and Dosage: For prophylactic use only in an-ıa pectoris, 1 capsule every 12 hours. **Precautions:** For ophylaxis only, not for relief of acute anginal attacks. lerance to nitrites may develop on long-continued use. **ntraindications:** Idiosyncrasy to nitroglycerin, and rly myocardial infarction. **Side Effects:** With use of trites, transient headache, postural hypotension, nausea and vomiting may occur. Overdoses may cause flushing, dizziness, tachycardia, headache and syncope.

***The micro-dialysis cell.** Nitrospan's timed-release mechanism is different from those usually employed in sustained-action capsules, which rely on unpredictable digestive processes. The nitroglycerin in Nitrospan capsules is contained within hundreds of dialysis cells of controlled permeability. The contents of each micro-dialysis cell are released by diffusion rather than disintegration, at a continuous rate independent of gastrointestinal action. Only the presence of fluid is required.



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CAPSULES

brand of **nitroglycerin** 2.5 mg. in micro-dialysis cells

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MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND

April 21-28

Caribbean Cruise Convention

Sunday, April 21	—Sail from Baltimore at approximately 4:00 p.m.
Monday, April 22 and Tuesday, April 23	—Scientific sessions and films aboard ship, with time for fun - sunning, swimming, entertainment, dancing, movies, and excellent food
Wednesday, April 24	—Scientific session and film in a.m. Arrive San Juan about 1:00 p.m.
Thursday, April 25	—Arrive in St. Thomas about 9:00 a.m.
Friday, April 26 and Saturday, April 27	— Scientific sessions and films aboard ship, with time for fun as noted above
Sunday, April 28	—Arrive in Baltimore about 2:00 p.m.

For Cruise Convention reservations contact
Travel Guide Agency Ltd.
416 North Charles Street
Baltimore, Maryland 21201 (Telephone: SAratoga 7-1696)

SCIENTIFIC EXHIBIT AWARD

MEDICAL AND CHIRURGICAL FACULTY ANNUAL MEETING

APRIL 17, 18, 19, The Alcazar, Baltimore

The Medical and Chirurgical Faculty, in cooperation with Mead Johnson Laboratories, will again present an AESCULAPIUS AWARD for the outstanding scientific exhibit displayed at the 1968 Annual Meeting. This award is designed to recognize and reward excellence in concept, originality, and execution of a scientific exhibit.

A committee of the Medical Society will be the judges and the winner will be presented with a certificate, suitably inscribed with the title of the exhibit and the author's name. A prize of $200.00, donated by Mead Johnson Laboratories, will be presented to the winner during the convention.

All scientific exhibits accepted for showing at the 1968 Annual Meeting of the Faculty will be eligible for judging. Physicians interested in submitting exhibits should make application to the Chairman, Committee on Program and Arrangements, Medical and Chirurgical Faculty, 1211 Cathedral Street, Baltimore, Maryland 21201.

EXHIBIT SPACE IS LIMITED—SEND YOUR APPLICATION TODAY

1968 ANNUAL MEETING

April 17-19
In Baltimore

Wednesday, April 17—	9:30 a.m.	Meeting of House of Delegates, Alcazar
	12:30 p.m.	"Quiz the Experts" Luncheon, Sheraton-Belvedere Hotel
	2:15 p.m.	Scientific sessions begin, Alcazar
	8:15 p.m.	AMA-ERF Benefit performance at Morris Mechanic Theater
Thursday, April 18 —	9:30 a.m.	Medical Grand Rounds, Alcazar Presented by The Johns Hopkins University School of Medicine
	11:30 a.m.	Lecture
	2:15 p.m.	Surgical Grand Rounds, Alcazar Presented by the University of Maryland School of Medicine
	4:15 p.m.	Lecture
	6:15 p.m.	Annual Presidential Reception and Dinner, Sheraton-Belvedere Hotel
Friday, April 19 —	9:30 a.m.	Scientific sessions begin, Alcazar
	2:00 p.m.	Meeting of House of Delegates, Faculty Building

To help the physicians keep abreast of recent scientific advancement, there will be many scientific and technical exhibits on display at the Alcazar.

The Health Evaluation Tests, one of the most popular features of the Annual Meeting, will again be available at the Alcazar for physicians and their families. This is a valuable benefit of membership in the Faculty.

Committee on Program and Arrangements
Thaddeus E. Prout, MD, Chairman

DO YOU HAVE A TECHNICAL EXHIBIT

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APRIL 17, 18, 19, 1968, The Alcazar, Baltimore

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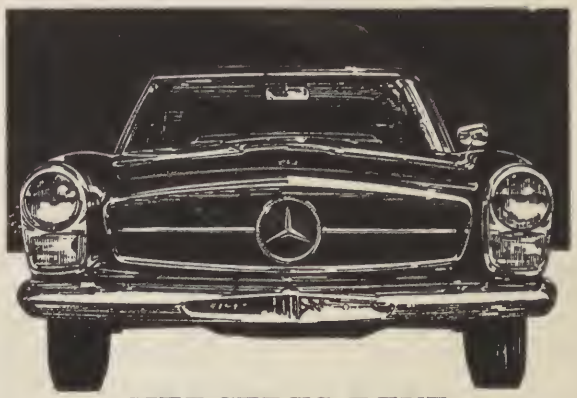
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EXECUTIVE SECRETARY'S NEWSLETTER

December, 1967

MEDICAID PAYMENTS FOR INHOSPITAL CARE

The State Health Department has sent to those who requested it a procedures manual and new forms MS 9 for submitting of bills for payment for services rendered to Medicaid patients in hospitals.

Payments are retroactive to July 1, 1967; and payments should be billed on the basis of the Physician's Usual, Customary and Reasonable fees. Payments will be made on a percentage basis, within State Health Department budget limitations.

Those physicians who have not received their manuals and forms should contact Mr. John Morris, State Health Department, 301 West Preston Street, Baltimore, Maryland 21201.

1968 DUES BILLS

Dues bills for 1968 are in the mail now. Physicians are reminded that payment of dues must be made BEFORE JANUARY 31, 1968, in order to be eligible for Physicians' Defense.

The Council has ruled that strict interpretation of the Faculty's Bylaws will preclude authorization of this benefit of membership if members do not comply with this Bylaw requirement.

ANNUAL MEETING RESOLUTIONS

Deadline for submission of resolutions for consideration at the Faculty's Annual Meeting, April 17 - 19, 1968, is

WEDNESDAY, FEBRUARY 21, 1968

Resolutions received in the Faculty office after that date may not be considered at the Annual Meeting.

Members are reminded of the recent Bylaw change requiring resolutions introduced by individual members to have the endorsement of either one-third of his component society membership or 30 members of his component society, whichever is smaller.

NEWS NOTES

Marvin Cornblath, M.D., is the new professor and head of the Department of Pediatrics at the University of Maryland School of Medicine. He

will assume his new duties September 1, 1968.

H. Vasken Apashian, M.D., formerly with Tufts University School of Medicine, has become the new head of the Department of Cell Biology and Pharmacology, also at the University of Maryland School of Medicine.

Joe Price, D.D.S., will speak on "The Challenge of Prepaid Dentistry" at the Professional Forum meeting, Thursday, December 19, at the Baltimore Country Club. Reservations may be made through the Professional Forum office at 613 Munsey Building, Baltimore, 21202.

WAGE AND SALARY COMPARISON

Recently a study was conducted of union-oriented tradesmen. The following result was obtained:

Carpenters	$4.44 per hour	(40 hour week)
Electricians	$5.05 per hour	(40 hour week)
Plumbers	$4.94 per hour	(40 hour week)
Linotype Operators	$4.20 per hour	(36 hour, 40 minute week)
Bricklayers	$5.40 per hour	(40 hour week)

Based on this and computing on a basis of 40 hours straight time and 48 hours overtime, for which time and a half is paid, we arrive at the following annual income figures:

	40 hour week	88 hour week
Carpenters	$ 9,235.00	$25,844.00
Electricians	10,504.00	29,380.00
Plumbers	10,275.00	28,340.00
Linotype Operators	8,060.00	24,440.00
Bricklayers	11,232.00	31,408.00

The 88 hour week figure used is based on the average work week of the practicing physician.

John Sargeant

Executive Secretary

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Your MEDICAL FACULTY at Work

JOHN SARGEANT EXECUTIVE SECRETARY

The Executive Committee at its meeting on November 11, 1967, took the following action:

1. Authorized the annual staff Christmas party

2. Authorized the Executive Secretary to determine any special building closing arrangements over the Christmas and New Year holidays

3. Authorized attendance of a staff member at the Professional Convention Management Association meeting, January 2-4, 1968

4. Deferred action on installation of a silent call system for paging physicians attending meetings in Osler Hall

5. Approved a recommendation of the Policy and Planning Committee and authorized up to $1,000 per year for the preparation of a history of all component societies, with such being done over a period of time

6. Approved action taken in connection with a possible case of the practice of medicine by a lay person.

7. Deferred discussion to the January, 1968, Council meeting in connection with a Health Manpower Resources Program

8. Reaffirmed its previous action in rejecting a request for payment of a Subcommittee chairman's expenses to attend a scientific meeting

9. Received an acknowledgment of memorial tribute from Mrs. Helen Baumgartner

10. Approved action of the Council Chairman and President in urging appointment by the Governor to the State Board of Health and Mental Hygiene of Robert W. Gibson, MD.

11. Approved participation in the newly-formed Maryland Advisory Council on Eye Care, in cooperation with the District of Columbia and Virginia; with the understanding that no expenses would be involved

12. Authorized on recommendation of the Editorial Board of the Journal and subject to approval of legal counsel, participation in a royalty arrangement with University Microfilms Library Services and Academic Archives, Inc.

13. Discussed the services provided by legal counsel in return for the Faculty's annual retainer

14. Adopted a motion in connection with the death of Frank K. Morris, MD, Secretary-Treasurer of the Board of Medical Examiners.

* * * * *

The House of Delegates in special session on Saturday, November 11, 1967, took the following action:

1. Adopted a proposed Commission on Medical Discipline with the understanding that it serve as a guide to the Faculty's legislative representatives in Annapolis

2. Observed a moment's silence in memory of the late Frank K. Morris, MD, Secretary-Treasurer of the Board of Medical Examiners.

The Council at its November 16, 1967, session took the following action:

1. Introduced Paul F. Guerin, MD, who became a member of the Council by virtue of his election as Chairman of the Library and History Committee

2. Introduced the new AMA Field Representative, Gerald Blanchard, who has been assigned Maryland as one of his states in the territory he covers.

3. Approved recommendation for Emeritus Membership to the House of Delegates for a member on request of his component society

4. Adopted 1968 Council meeting dates.

5. Ratified legal defense for physicians requesting it

6. Approved the principle of Laboratories reporting to the State Health Department findings "suggestive" of gonorrhea, syphilis or tuberculosis; with the understanding that no patient contact will be made without the consent of the attending physician.

7. Adopted a policy of telephone listings to be applied on a statewide basis for yellow pages of telephone books. This is as follows:

Recognizing that a single, statewide policy should be in existence with respect to physician listings in the "yellow pages" or classified telephone directory listings, because many telephone books cross over political subdivision lines, the Mediation Committee recommends adoption of the following policy:

1. Listings shall be made under the heading Physicians and Surgeons. It is understood that where a physician has a specialty that warrants listing under another heading, this is permissible. (such as Clinical Laboratories)
2. Listings may include the following *ONLY*:
   name, address and phone number; office hours; an "if no answer" number; "physicians" or "surgeons" home address and telephone number;
3. Listings may be made *only* as follows:
   Practice limited to . . . (using only those specialties approved by the American Medical Association or as modified and approved by a special liaison group to be named by the Faculty to work with the C & P Telephone Company)
4. Listings must be uniform in size and type face.
5. Display or box advertisements are strictly prohibited.
6. Listings may not be carried in a telephone directory where he does not have an office or residence, except in combined area directories where a listing may be published in all three yellow page directories, viz., Washington, Maryland Suburban, Virginia Suburban, Baltimore City, Baltimore Suburban West, Baltimore Suburban East.
7. It is preferable for physicians to list the letters "MD" following their name rather than the title "Dr." preceding their name, inasmuch as this leaves no doubt that the person listed is a medical doctor. At times, other types of "doctorates" can be listed in error.
8. Where multiple offices of a physician are listed, each office listing MAY NOT be preceded by the words "Physicians Office." The same applies to any other category of listing that might arise.
9. The Medical and Chirurgical Faculty may list, in the Metropolitan Baltimore area, a telephone number where the public may call to receive assistance in selecting a physician.
10. Items 2, 3, 4, 6 and 7 apply also to telephone directory listings in the White pages.

8. Adopted the following policy with respect to educational programs for pregnant girls:

The problem of providing for the education of the pregnant student in the Public School System must be solved on an individual basis in accordance with the needs of the student and the capabilities of the local school system. While hard and fast rules cannot be made, the following general principles should be heeded.

1. An opportunity should be provided for all pregnant girls to receive their education through all grade levels.
2. Of the two possible choices, home teaching vs. school teaching, the latter is to be desired, in most cases. The pregnant student may be accommodated in the regular classroom until transfer is recommended by the physician or principal or requested by the student.
3. Transfer at the appropriate time should be made to one of the following three settings.
   a. Special classroom in a regular school
   b. Special school
   c. Home teaching
4. The pregnant student shall be obliged to have routine prenatal medical supervision. A medical report containing information pertinent to her school activities shall be required on a monthly basis from each pregnant student.
5. The curriculum provided each pregnant student should be supplemented with appropriate material pertinent to the student's situation.

9. Received with appreciation a check for $600.00 from Henry P. Laughlin, MD, to be added to the Laughlin dedicated fund

10. Referred to the Treasurer for possible inclusion in the 1968 budget a request for up to $1,000 from annual meeting income for use

in conducting the health evaluation tests for members at the annual meeting.

11. Adopted the following resolution with the understanding that it be transmitted to Maryland's congressional delegation:

WHEREAS, considerable confusion of the public will be created by defining as "physician" in federal law, persons other than those fully licensed to practice medicine and surgery; and

WHEREAS, H.R. 12080, adopted by the House of Representatives, U. S. Congress, and now up for consideration in the U. S. Senate, provides for a broadening of the definition of the term "physician" by amending this definition to include a doctor of podiatry with respect to the functions he is authorized to perform under the laws of the State in which he works; and

WHEREAS, The U. S. Senate has broadened this still further to include under the same title the same provision with respect to Chiropractors; and

WHEREAS, The definition of a physician as adopted by the *AMA* House of Delegates is:

"A physician is one who has acquired a contemporary education in the fundamental and special sciences, comprehended in the general term 'medicine' used in its unrestricted sense, and who has received the degree of Doctor of Medicine from a medical school of recognized standing," and

WHEREAS, The Attorney-General's office of the State of Maryland has issued legal opinions stating that only Doctors of Medicine may identify themselves by the term "physician," and

WHEREAS, The Medical and Chirurgical Faculty of the State of Maryland recognizes the work of Podiatrists and the great assistance they can be to doctors of medicine; and

WHEREAS, The Medical and Chirurgical Faculty of the State of Maryland has consistently opposed the concept of Chiropractic, and continues to do so; therefore, be it

RESOLVED, That the Medical and Chirurgical Faculty of the State of Maryland expresses itself as being opposed to the inclusion of any other professions or persons in the definition of "physician" as adopted by Federal Statute, unless that person truly is a qualified Doctor of Medicine or is licensed to practice unrestricted medicine and surgery.

12. Approved participation in a special Gubernatorial project with the understanding that the Executive Committee will name members to work on this project; and that the Faculty's recommendations would be in an advisory capacity only.

13. Appointed legal counsel for the 1968 year

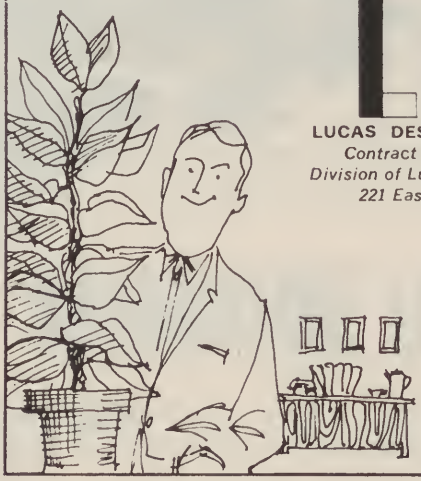
14. Deferred action on the suggestion that a committee be named to discuss long range building needs of the Faculty. Such action can only be taken after the Library's present program of collection evaluation is completed.

15. Named a committee to consider an appropriate honor for Louis Krause, MD, who has retired as Library Committee chairman. Dr. Krause continues to serve on the committee

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From Baltimore

The American Cancer Society, Maryland Division, Inc., has announced a new program of cancer study fellowships.

John A. Wagner, MD, Chairman of the Division Professional Education Committee, said that fellowships are available to visit specific laboratories or clinics within the United States. The purpose of the grant is for physicians to acquire particular skills with respect to research, specific diagnostic techniques or specific therapy as related to neoplastic disease. The travel fellowship can provide transportation and room and board to those physicians, who due to budgetary restrictions, find travel money unavailable for this type of study.

Dr. Wagner pointed out that the grant applicant must be a medical educator at a recognized teaching institution or community hospital in Maryland. Applications should be made at least two full months prior to the anticipated date of travel, he said.

According to Dr. Wagner, a Sub-Committee headed by Conrad Julian, MD, has been appointed to receive and review grant applications. Details will be made available shortly to all medical institutions in the state.

Inquiries concerning cancer study fellowships should be directed to Dr. Conrad Julian, American Cancer Society, Maryland Division, Inc., 20 East Eager Street, Baltimore, Maryland 21202.

From Chicago

Five new medical schools were opened this fall, and others are increasing their enrollments of beginning medical students.

The result is an increase of first-year medical students to an estimated 9,280, compared with 8,964 last year, says The *AMA* News, published by the American Medical Association.

There now are 94 US medical schools in operation. Eleven other new medical schools are continuing development programs. These developing schools, plus the five just put into operation, are expected to be graduating an additional 1,062 medical students annually by the mid-1970s. Medical schools will then be graduating about 10,000 students annually.

Total medical school enrollment was 82,835 last year, and is expected to increase substantially this year.

The new schools are the University of Arizona College of Medicine, at Tucson; Brown University's Program in Medical Science, at Providence, R.I.; the University of Hawaii School of Medicine, at Honolulu; Michigan State University's College of Human Medicine, at East Lansing; and Pennsylvania State University's Milton S. Hershey Medical Center, Hershey, Pa.

In addition, freshman enrollment has been increased five each in the schools of medicine and dentistry at Creighton University, Omaha, Neb. The increases will boost medical school enrollment to 82 freshmen and the dentistry division enrollment to 51 freshmen.

Students are expected to be admitted in September, 1968—two years ahead of schedule—to the new campus of the New Jersey College of Medicine and Dentistry in Newark. This is a new campus for an existing medical school.

The University of Arizona welcomed a class of 32 when it opened its $7.3 million medical school complex in September. A full enrollment of 64 students is expected about 1969, according to Merlin K. DuVal, Jr., MD, dean of the school.

While Brown University admitted its first medical school students in 1963, that class this fall reached the equivalent of its first medical year. Under the direction of Mac V. Edds, Jr., MD, this privately owned and supported university has earmarked a $17.1 million medical school expansion program. The medical school offers a six-year program, with the final three years emphasizing independent study and research. The school envisions a maximum enrollment to 50 students per class.

Twenty-seven students are enrolled in the University of Hawaii's School of Medicine. Windsor C. Cutting, MD., dean, says construction is expected to start within the next six months on a $7 million medical school building, but meanwhile, classes are being conducted in other campus buildings, as well as in Leahi Hospital.

Michigan State University's College of Human Medicine is directed by Andrew D. Hunt, Jr., MD, dean. Categorized as a "two-year" school, its program is considered as a "continuous six-year experience," with "medical school" training starting in the fourth year after three years of undergraduate work. The school is aiming for an enrollment of 64 students per class and is completing plans for an $11.8 million Life Sciences Building.

A class of 40 is enrolled in the new College of Medicine of the Milton S. Hershey Center of Pennsylvania State University. The $50 million complex, under Dean George T. Harrell, Jr., MD, has devised an education program which will "emphasize problem solving through the scientific method."

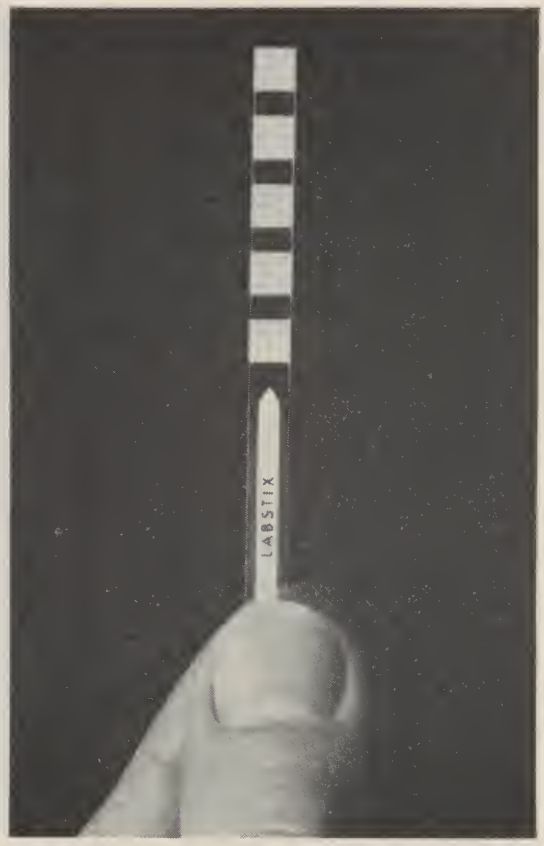
While reporting the good news of school openings, The *AMA* News also gave an editorial warning.

"The American Medical Association's Board of Trustees has stated that while medical school output will continue to increase steadily, the increase will probably not be sufficient to resolve the medical manpower problem," the editorial said.

"Medical educators know it takes from six to ten years from the time it is decided to build a new medical school until the graduation of the first class. It requires a minimum of three years after money is available to develop a medical school to the point where it will enroll its first class.

"Expansion of an existing medical school, while the most rapid way to achieve the desired increase in physicians, still requires time. At least two and one-half years are required to plan and build facilities which will allow for a major expansion of a medical school's classes."

The five new medical schools "can serve as inspirations," the editorial said, but they ought to serve as warnings that "the time to act—the time to begin planning and gaining the necessary sup-



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port for a new school or the expansion of an existing one—is now."

SPECIALTY BOARD RULING IS ISSUED

The Judicial Council of the American Medical Association has found that the resolution on unapproved specialty boards adopted by the House of Delegates at the 1967 Annual Convention was not based upon evidence of unethical conduct.

The Council considered the matter at the request of the American Board of Abdominal Surgery and the American Society of Abdominal Surgeons, charging that Resolution 123 as amended and adopted "constitutes an unwarranted and improper censure" of the *AMA* members who are also members of the two organizations.

NOT A VIOLATION—The findings of the Council also stated that the Council has jurisdiction to determine the issues involved, and that Resolution 123 "should not be construed or interpreted as a determination of any violation of the Constitutions and Bylaws or the Principles of Medical Ethics of the American Medical Association on the part of the petitioners or those members of the *AMA* who are similarly involved."

Resolution 123, introduced by John W. Cline, MD, past president of the *AMA* from San Francisco, stated that the *AMA* took "cognizance of the recent action of the American Board of Abdominal Surgery, which Board is not approved by the *AMA*, and has acted in defiance of the House of Delegates."

Dr. Cline was invited to appear before the Council, and spoke concerning the introduction and adoption of the resolution.

Council Statement: "Within the frame of reference of Resolution 123 as adopted by the House of Delegates," the Council statement said, "the testimony given at the hearing disclosed no evidence which would establish that the Petitioners or members of the American Board of Abdominal Surgery and the American Society of Abdominal Surgeons have acted in violation of the Constitution and Bylaws or the Principles of Medical Ethics of the American Medical Association."

Blaise Alfano, MD, Melrose, Mass., secretary of the American Board of Abdominal Surgery, and one of the physicians who requested the opinion, commented that he was pleased with the decision, and said this clears up the controversy.



Edward J. Krol, MD, Chicago, chairman of the board of the same group, commented:

"I think the American Board of Abdominal Surgery and the Society have been vindicated by this action of the Judicial Council.

"I am encouraged by this demonstration that we have a real democracy in the *AMA*," Dr. Krol added.

New developments in the rehabilitation of the handicapped were covered in depth during the annual convention of the National Society for Crippled Children and Adults (the Easter Seal Society) held November 16-19 at the Century Plaza Hotel, Los Angeles.

Among these, medical and educational aspects of learning disorders in children, only recently identified as a major handicapping problem, were examined at a seminar moderated by Samuel Clements, Ph.D., director of the National Project on Minimal Brain Dysfunction. This was followed by a demonstration of the team approach to the problem in which distinguished leaders in medical, psychological and educational fields participated.

Bob Considine, columnist, author and broadcaster, spoke on a new Home Safety Program being sponsored by the National Society.

Hundreds of Easter Seal board members, volunteers and professional staff members from every state and Puerto Rico gathered to hear from outstanding authorities in virtually every aspect of crippling. Subjects covered a wide range including the duties and responsibilities of the Society, its relationships with other agencies and government, and ways and means of improving and expanding rehabilitation services for crippled children and adults.

Vernon R. Alden, president of Ohio University, and Lisle C. Carter, assistant secretary for Individual and Family Services, US Department of Health, Education and Welfare, keynoted the convention's opening session.

Opportunities for government cooperation in planning for comprehensive personal health services were discussed by Carruth J. Wagner, MD, assistant surgeon general and director, Bureau of Health Services, US Public Health Service; Jerrold M. Michael, assistant surgeon general and assistant director, Bureau of Health Services, and

C. Wayne Tucker, deputy assistant director, Bureau of Health Insurance, Social Security Administration.

George Shapiro, PhD, associate professor, University of Minnesota, conducted a communications institute and there were sessions for parents of handicapped children; also others on volunteer leadership and board responsibility, and for state and local Easter Seal presidents.

Mrs. Billy Graham, wife of the renowned Evangelist, received a "Volunteer of the Year" award and Dinah Shore, 1968 Easter Seal Campaign chairman, was a special guest at a dinner honoring President Mangelsdorf.

Chairman of the convention committee was Leon Chatelain, Jr., Washington, D.C., and Don Belding, Pacific Palisades, was chairman of the California host committee. Sumner G. Whittier was executive director of the National Society and Miss Jayne Shover was convention coordinator.

From New York

The Executive Committee of the American Society of Bariatrics today announced the Society's endorsement of the American Medical Association's statement of Policy Regarding Weight Reduction Practices.

In addition, the Society has issued its own statement of policy regarding weight reduction practices which reads, in part:

"Members of the American Society of Bariatrics recognize that obesity is a panorama of diseases of multiple etiologies and with multiple signs and symptoms. They are required by their membership in the American Society of Bariatrics to obtain a complete patient history including full laboratory and physical tests to reveal the possibility and extent of disease conditions.

"The American Society of Bariatrics is opposed to physicians who do not conduct their bariatric practices in accordance with the above conditions and with the standards of the Society as set forth in its constitution and by-laws."

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From Washington

A group of advisors to the Public Health Service and an *AMA* official separately emphasized the seriousness of the health manpower problem.

The Allied Health Professions Education Subcommittee of the National Advisory Health Council said in a report to the *PHS* surgeon general, William H. Stewart, MD, that health manpower is the critical factor in the provision of health services in this nation.

"With the rising capacity of medicine to provide a satisfying array of services, the lowering of financial barriers to service, and the growing acceptance of a public responsibility to assure that all people have adequate medical service, needs and demands for medical care continue to outstrip their availability," the report said.

"Many people are struggling with approaches to the measurement of health manpower shortages. But no one figure can express the total need. And even if it were possible to envision ideal health services staffing for a community, a state, or a nation, the continuing development of new knowledge and techniques, new patterns of service, and new methods of payment are constantly changing the needs, both for numbers and varieties of health workers."

* * * * *

BRAIN DRAIN

Alvin J. Ingram MD, of Memphis, Tenn., a member of the *AMA* Board of Trustees, told the *AMA* Conference on Aging and Long-term Care in Baltimore, Md., that there is an urgent need for all categories of health personnel.

"We have been challenged by government to revamp our system of health care, to make it available to every one and to do so more economically than at present," Dr. Ingram said. "To do this will require not only larger numbers of health personnel, but more coordinated and efficient use of all members of the health team.

"The basic purpose of all of medicine—research, education and practice—is the application of the art and science of the profession to the individual patient or to the community as a whole.

"Furthermore, we are constantly exposed to remarks about the brain drain, the siphoning of physicians trained in other countries and their acceptance here to fill our own voids, even at the expense of intensifying already desperate shortages in other nations.

"Yet we have our brain drain in this country—the consistent and progressive decrease in the ranks of practicing physicians as members of the profession turn from the primary responsibility of patient care to research, teaching and administrative service. In the past 15 years, the number of physicians in full time private practice has decreased at the rate of almost *one per cent* a year, from 75% in 1950 to 62% in 1965."

Dr. Ingram decried the growing dependence of the nation's health care system on foreign physicians.

"This dilemma can hardly be exaggerated," Dr. Ingram said. "Not one foreign graduate meets our domestic requirements which include graduation from an approved medical school which has undergone regular, competent inspection."

Dr. Ingram cited government figures showing that the percentage of foreign physicians in the United States had risen from 16% in 1956 to 26% in 1966 and that nearly half of them were from under-developed or developing countries that badly need their services at home.

* * * * *

INEFFICIENT ADMINISTRATION OF RESEARCH GRANT

The House Committee on Government Operations has issued its third report charging costly and inefficient administration of research grant programs by the National Institutes of Health and other Public Health Service bureaus.

The Congressional watchdog panel said the *PHS* had made relatively little effort to improve its administration of grants since the committee's two previous reports in 1961 and 1962.

"Inadequate administrative performance is demonstrated, for example, by the inept handling of payments for the indirect research costs of grantees and the extremely poor administration of the General Research Support and Health Sciences Advancement Award programs," the recent report said.



"NIH and other *PHS* bureaus were found to have made excessive indirect cost payments to grantees." (About $500,000 in one case).

The *AMA* supported legislation to continue federal aid for construction, training and research under the Health, Education and Welfare Department's retardation program, but opposes grants to help pay for initial staffing.

The *AMA* position was outlined by F.J.L. Blasingame, MD, *AMA* executive vice president, in a letter to the *House* Public Health and Welfare Subcommittee. He said:

"The extent to which the problem of mental retardation can be ameliorated in future years depends largely upon continued research. Although some breakthroughs have been effected such as the prevention of some types of mental retardation as a result of our increased knowledge of body metabolism, there are still gaps in research, personnel and financing which must be overcome. While the ultimate answer to the problem of mental retardation is prevention, we recognize that in the meantime, mentally retarded individuals must be cared for and must be educated and trained to the limit of their capabilities.

"In this regard, the *AMA* supports efforts to provide higher standards of care for the institutionalized retarded, special educational programs day care centers within the community, counseling services for the parents of retarded children, and efforts to create job opportunities for retarded adults. For these programs to be effective, the nation needs additional facilities and an increase in properly qualified personnel. We, therefore, are pleased to submit for the record our continued support of the expansion, extension and improvement of facilities and services through construction, training and research grants. . .

"The bill, however, also amends the present Act to authorize grants for meeting a portion of the cost of compensating professional and technical personnel during the initial operation of the facility. Although such federal financial assistance during the early years might enable a mental retardation facility to undertake a more comprehensive program than it might otherwise attempt, it can be demonstrated that once reliance is placed on a federal subsidy for staffing, the role of the federal government as a provider of operating funds will not easily be ended. Once a facility has been constructed, the community can and should as-

sume the responsibility for its operation, including the costs of staffing."

ANNUAL REPORT ON MEDICAL EDUCATION

This year's entering class at US and Canadian medical schools is the largest in history: approximately 9,280 freshman medical students, up from last year's 8,964, reports the current (Nov. 20) Journal of the American Medical Association.

Part of the increase is due to the 137 students admitted to five new medical schools which opened this fall. Two new US medical schools and one new Canadian medical school began operations in recent years. (Nine more US and three Canadian medical schools are continuing their development.)

By the mid-1970s, these 20 new schools are expected to be graduating an additional 1,653 medical students annually. About 10,000 medical students will be graduated annually by 1975, according to medical school deans' estimates. The total graduated from US medical schools during the past year was 7,743—a record, and up 169 from the preceding year's total.

These and other statistics concerning US and Canadian medical education are in the 67th annual report of the *AMA*'s Council on Medical Education, published in the current Journal of the *AMA*.

Enrollment was at a new high in American Medical schools in the academic year 1966-67, the report said. The total was 33,423 students, up from the precedings year's 32,835.

Thirty-two existing medical schools have been awarded federal grants to expand facilities, enabling them to accommodate an additional 792 students in first-year classes. Expansion grants have been approved, but not yet funded, for five more schools. These expansions would add 92 more first-year openings.

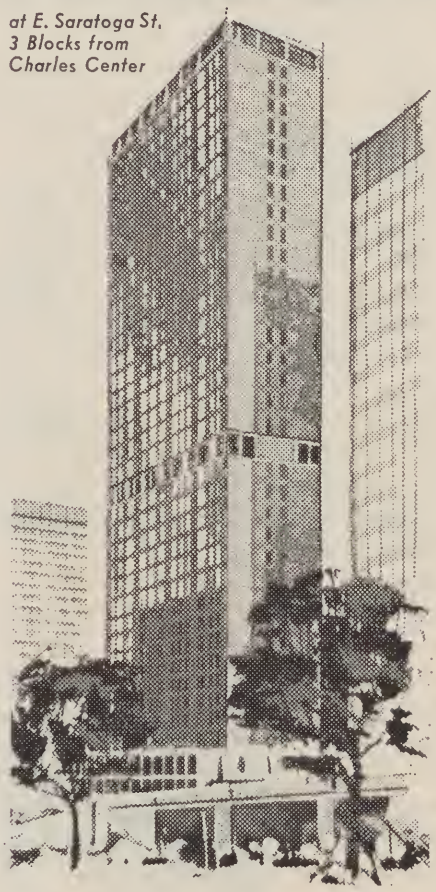
The *AMA*'s Board of Trustees has said that "an immediate and unprecedented increase in physician output is needed." The most rapid way to achieve this without sacrificing educational quality is to expand existing medical schools, the Board said.

The Journal report points out that some states are the source of more medical students than their schools can accommodate, notably California, New York, and New Jersey. In some instances,

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however, there is a later return of medical interns and residents to those states, where they stay on in practice.

Other states, (particularly Massachusetts, Pennsylvania, and the District of Columbia) admit large numbers of out-of-state medical students.

Oregon and Georgia are examples of states that maintain a fairly even balance of students entering medical school, medical students educated, interns and residents trained, etc.

The study also shows that New York ranks first in the number of entering medical students per 100,000 population (7.5 per 100,000, or a total of 1,353 freshman students this year).

North Dakota is second in the number of entering medical students in relation to its total population; Nebraska, Utah, the District of Columbia, and New Jersey follow, in that order. California ranks 43rd in this category, although it ranks third in total numbers of entering medical students.

As of Sept. 1, 1966, there were 48,656 US, Canadian, and foreign medical graduates in US graduate medical education leading toward licensure, general or specialty practice, or specialty board certification.

Of this total, 10,366 were interns, 32,050 were residents, and 6,240 were in other types of training.

Americans also go abroad for medical study. A few enter Canadian medical schools, and considerably more turn to medical schools in other countries. The Institute of International Education reported that in 1966-67, there were 2,377 US citizens working toward medical degrees in foreign schools.

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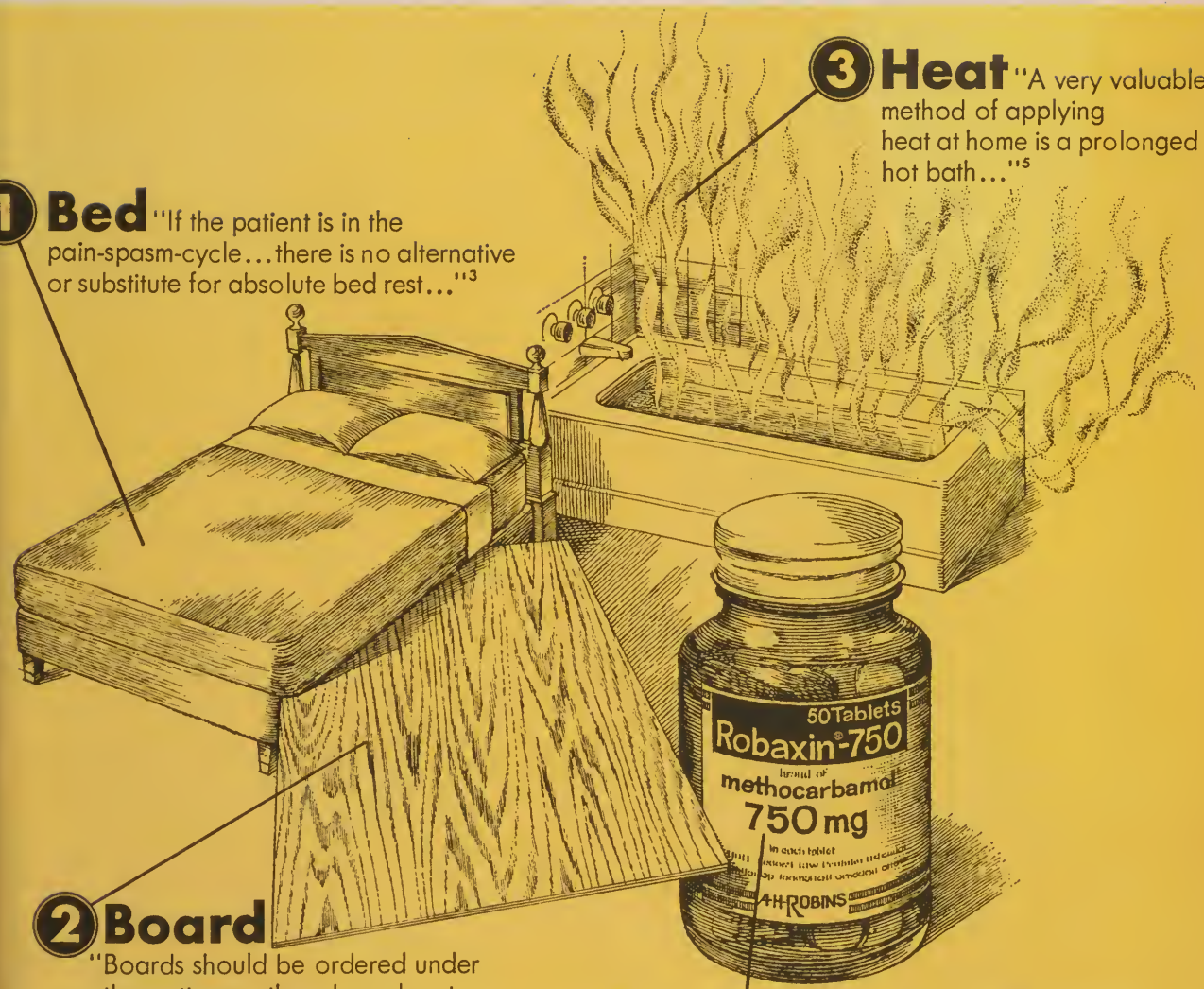
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LOW-BACK PAIN

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The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.[1,2] For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:



1 Bed "If the patient is in the pain-spasm-cycle...there is no alternative or substitute for absolute bed rest..."[3]

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Rerences: (1). Godfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gottschalk, L.: GP 33:91, 1966. (3). Rowe, M.L.: J. Occup. Med. 2:219, 1960. (. Cozen, L.: South Dakota J. Med. 18:26, 1965. (5). Soto-Hall, R.: Nd. Sc. 14:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteopath. A. 6 42, 1962. (7). Feuer, S.G., *et al.*: New York J. Med. 62:1985, 1962.

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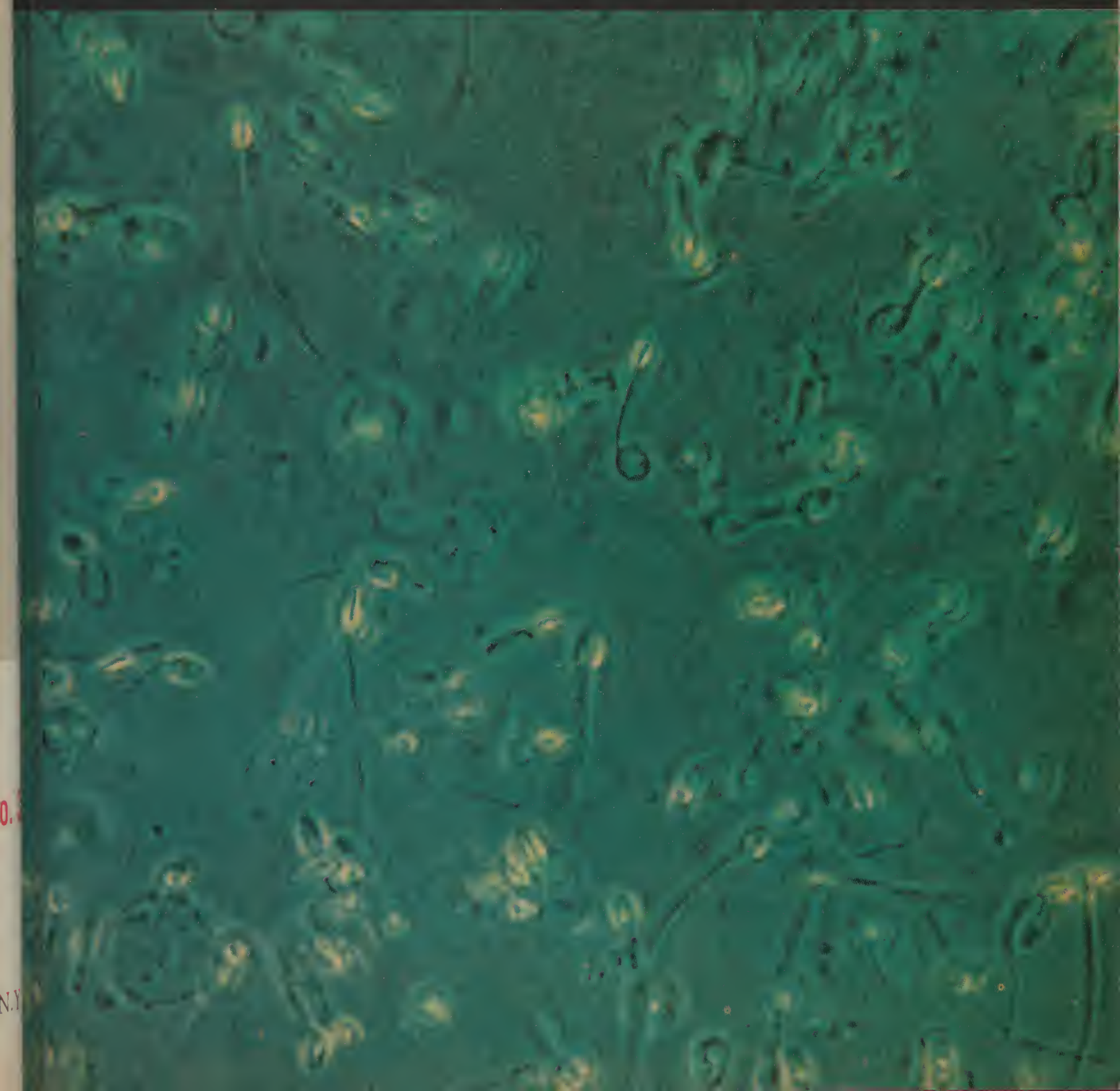
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Turn page for contraindications, precautions and side effects.



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

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In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Prescribing Information

Contraindications: Patients with any symptoms or history of thrombophlebitis, pulmonary embolism, liver dysfunction or disease, carcinoma of breast or genital organs, or undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. The safety of Norinyl-1 in pregnancy has not been demonstrated. If a patient misses two consecutive periods, pregnancy should be ruled out before continuing the medication. If she has not adhered to the prescribed schedule, pregnancy should be considered at the first missed period. Active ingredients of oral contraceptives have been detected in the milk of mothers who received these drugs; the significance to infants has not been determined.

Precautions: Pretreatment physical should include examination of the breasts and pelvic organs, as well as a Papanicolaou smear. If endocrine or liver function tests are abnormal during therapy, repeat tests are recommended after the drug has been withdrawn for two months. Following administration of drug, preexisting uterine fibromyomata may increase in size. Careful observation and caution are required for patients with symptoms or history of epilepsy, migraine, asthma, cardiac or renal dysfunction, cerebrovascular accident, psychic depression, and diabetes. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Possible long-term effects of the drug on pituitary, ovarian, adrenal, hepatic or uterine function must await further studies. The physician should be alert to the earliest manifestations of thrombophlebitis and pulmonary embolism. The drug should be used judiciously in those young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask symptoms of the climacteric. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following side effects have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation posttreatment, premenstruallike syndrome, changes in libido, changes in appetite, cystitislike syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, and itching. The following occurrences have been observed in users of oral contraceptives (a cause and effect relationship has neither been established nor disproved): thrombophlebitis, pulmonary embolism, neurooocular lesions.

The following laboratory tests may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests, coagulation tests (increase in prothrombin, factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metyrapone test, pregnanediol determination.

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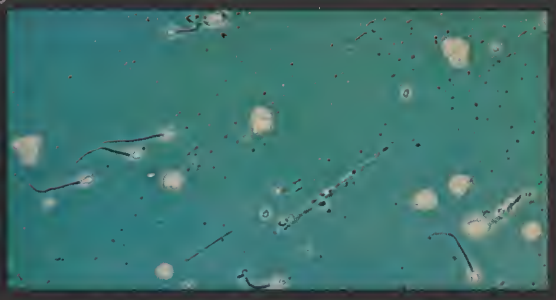
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

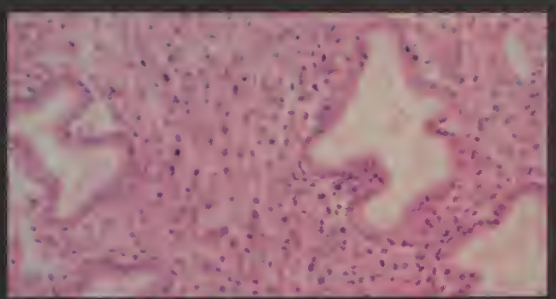
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.



Spermatozoa appear healthy, active, freemoving.

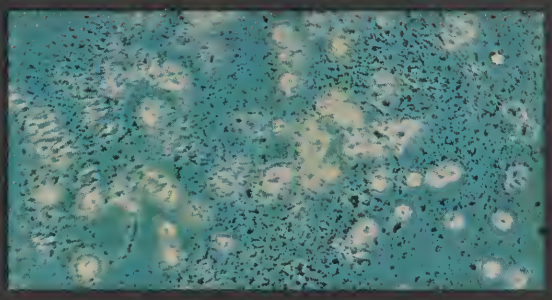


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

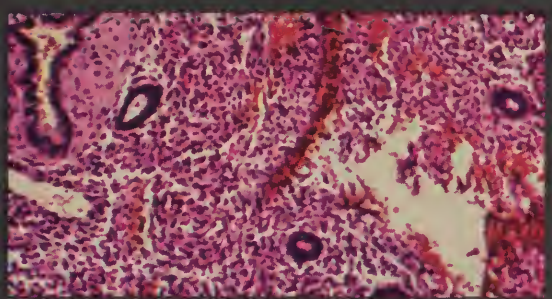
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



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Turn page for contraindicati... precautions and side effects

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Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. *Precautions:* Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. *Side Effects:* Side effects are uncommon with topical corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. In such cases the agent should be discontinued and appropriate measures taken. *Availability:* Synalar (fluocinolone acetonide) Cream 0.025%—5, 15 and 60 Gm. tubes and 425 Gm. jars. Cream 0.01%—15, 45 and 60 Gm. tubes and 120 Gm. jars. Solution 0.01%—20 and 60 cc. plastic squeeze bottles. Ointment 0.025%—15 and 60 Gm. tubes. Neo-Synalar® (neomycin sulfate 0.5% [0.35% neomycin base], fluocinolone acetonide 0.025%) Cream—5, 15 and 60 Gm. tubes.

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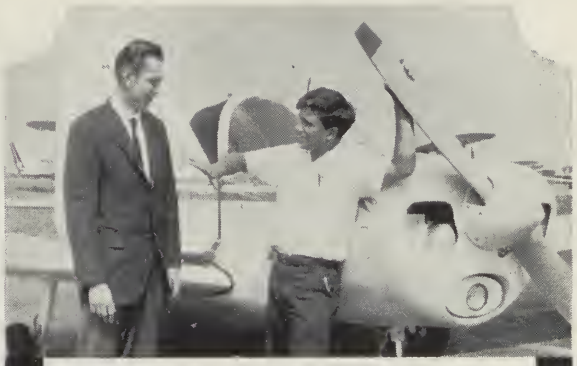
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arning: May be habit-forming.

ecautions: Tuinal should be used cautiously in paıts with decreased liver function, since prolongation effect may occur.

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[031767]

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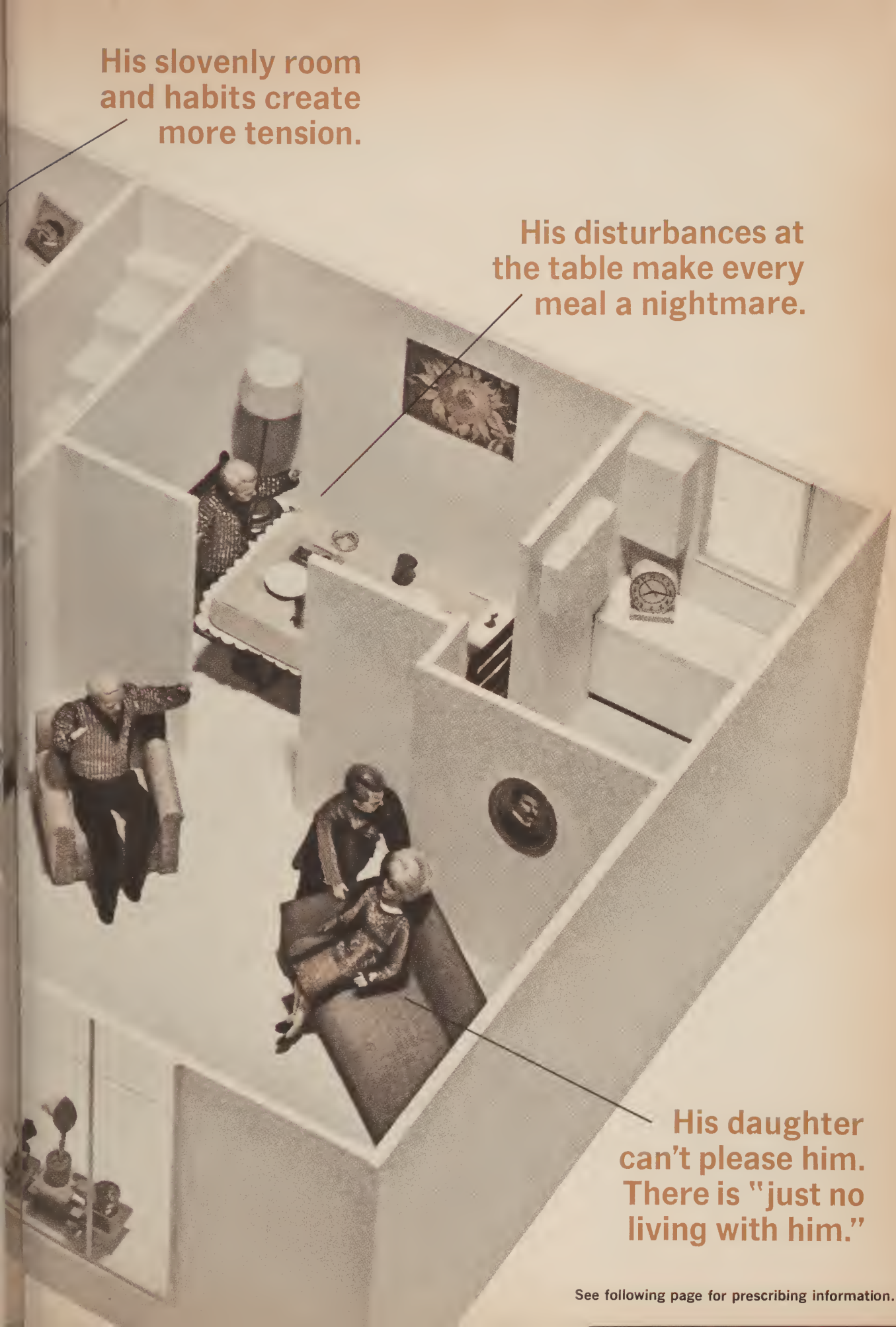
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Editorial

GENERIC VS TRADE NAMES

Ever since the late US Senator Estes Kefauver conducted his widely publicized drug investigations many years ago, the drug industry has been under fire by politicians anxious to make a name for themselves as guardians of the public's pocketbook. The latest in a series of hearings on this subject has given more publicity to the fallacy that the term *generic* means *cheaper* drugs with the same basic quality control that trade name drugs have.

At a recent Congressional hearing, the vice-president, Corporate Affairs, Eli Lilly and Company, Henry F. DeBoest, made certain cogent comments under questioning before the Monopoly Subcommittee of the *US* Senate's Select Committee on Small Business.

Because this Subcommittee had questioned the pricing of Seconal tablets, it was Mr. DeBoest's problem to justify this pricing policy and to endeavor to explain exactly why the Lilly product was higher in price than another *sodium secobarbital* product.

Ranging in explanation from the fact that the Senate Subcommittee had erred in the pricing of Seconal (reducing the price from $18.30 per thousand to $15.24), he was able to show that the cost per capsule was 6.8 cents for the trademark product compared to 6.3 cents for a generic substitute. He effectively refuted the charge of the Subcommittee that Lilly's product was sold at four times the price of the generic product.

However, the main points that Mr. DeBoest made were more far-reaching than this simple equation. He stated that, companies such as his emphasize scientific research, national distribution of product and full customer services; compared to those which have no research, regional distribution only of their products and limited customer service. What does this mean to the public and to the physician?

Scientific Research means consistency in the production of safe and effective products. This can often mean the difference between life and death. This means the physician may prescribe with confidence in a drug and the company that makes it.

It means quality of product—which, in turn, means that in research, in production or manufacture, raw materials, final product, packaging and labelling, this standard must be met.

As James L. Goddard, Food and Drug Commissioner, has said,

". . . if all drugs were reliable there would be a concrete basis for price comparison, and drugs could be included in a Formulary solely on a cost criteria."

Competition in Product line was another area touched upon. It was pointed out that drugs provided are packaged in various forms. Different dosage forms are needed in the treatment of different patients. Package sizes also vary. The so-called generic firms can concentrate on providing those product lines which are consumed in volume and thus avoid the little-used or no-profit item.

In addition, the full-product and full-distribution company must put itself in the position of providing its complete line of products everywhere in the country so as to be available to the patient wherever he may be. Some companies choose not to do this.

In times of disaster most of the ethical drug companies make themselves available to the Red Cross, US State Department and other agencies who are tending to the victims of fire, flood, earthquake and tornado.

In still another area, we find these same high-quality drug companies making available as fast as possible to the practicing physician the availability of new drugs, their uses and side-effects.

Backing up this enormous communications system are the specialists available on a 24-hour basis to the practitioner whenever he has a particular problem involved in the use of their drugs.

So, on and on went Mr. DeBoest, refuting many of the charges made for the publicity effect they would have.

In closing, he testified to the fact that his company manufactured *generic* drugs. In fact, some several hundred. But to equate these with "cheapness" was not true.

All in all, the testimony presented should give the Congressional investigators food for thought. We can only echo these closing remarks:

> "We feel strongly, however, that changes in our medical care system should be made with great caution, for the scientific, economic and social interrelationships of its many parts are in delicate balance. Experimenting with parts of any complex mechanism may seriously impair its capacity to perform effectively. We believe that competition among drug manufacturers and among drug distributors and pharmacists is insuring that sick people in this country receive high-quality drugs at prices well below the value which they contribute."



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SOME THOUGHTS ON THE SIDE EFFECTS OF ORAL CONTRACEPTIVES

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Annapolis, Maryland

Oral contraceptives are the most effective means of pregnancy prevention if one doesn't consider methods that are either impossible, like total abstinence, or impractical, like surgical removal of the female reproductive system.[1]

Pregnancy, its complications and its sequelae, creates a major world health problem. Examples are 1 to 1½ million estimated illegal abortions in the USA per year and population increase which eliminates per capita income increase in a country like India.[2, 3]

Faced with the opportunity to tackle a major health problem effectively the physician is confronted with the question of safety. This question cannot be answered completely and satisfactorily at present.[2, 4] We know that "the pill" is almost totally effective; we do not know that "the pill" is almost totally safe.

In this country oral contraceptives are available on a physician's prescription only. The physician has to take a stand.[4] Numerous difficult questions come up. Do you prescribe "the pill" at all? If you do, what are your standards for evaluating and selecting your patients? What do you tell them, how often do you see them back, for how many years do you give these potent hormones? The answers to these questions have to do with safety. For instance, can one give oral contraceptives to a woman with a past history of phlebitis, to a girl with a strong family history of breast cancer, to a patient who showed occasionally glycosuria during her last pregnancy, to a lady with frequent migraine attacks?

Not only the doctor who prescribes antifertility agents has to be aware of the answers to these questions; any practicing physician sees patients who have been placed on these drugs by one of his colleagues. The pediatrician finds that they influence lactation; the surgeon may see a very hyperemic thyroid gland; the neurologist has to consider them in the evaluation of a headache problem; the internist in the interpretation of abnormal laboratory data.

All oral contraceptives are combinations of synthetic steroids with potent hormone like effects. The principal sought after effect is guaranteed suppression of ovulation. As far as I have been able to determine all preparations presently available for doctor's prescription have this effect if taken according to instructions.[1]

As expected, a potent hormone capable of interfering predictably with one of the most essential functions of the female organism, must have other predictable effects. It does. Are those effects important or minimal, are they of significance in all patients, are they really predictable or are they erratic, are they simply annoying or dangerous and possibly even life threatening?

I shall not go into a complete enumeration of all the observed side effects of oral contraceptives. I do want to consider some of the more important and controversial areas in this field.

Consider the female reproductive system first. There are predictable changes in uterine endometrium and cervix, vagina and ovaries.[1] These changes appear to be reversible upon discontinuation of therapy.[6] So called sequential oral contraceptives which employ a high estrogen like effect in the early phase of drug administration

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cause hyperactivity of the cervical glands with production of a clear, odorless secretion, sometimes confused with leukorrhea from vaginitis. Vaginitis does not occur more frequently in users than in non-users of sequential preparations, but in the combination preparations vaginitis appears somewhat more frequently.[6] Cases of stubborn monilial vaginitis that only disappeared after discontinuing oral contraceptives have been reported.[7] There is no evidence that anti-fertility drugs increase the risk of cervical or uterine cancer during relatively short-term use.[1] Extensive studies in this regard have been undertaken and the popular "Pap"—smear has been of tremendous help. Oral contraceptives have actually been administered to women with abnormal cervical cytology and no deleterious effects, attributable to the drugs, have been observed.[8] It is felt however, that endometrial biopsy data after long term use are still incomplete.[6]

The ovary, being the most important target organ of anovulatory drugs via pituitary suppression, does show histological changes during this type of therapy, as expected.[1, 6] There has been no evidence that damage to the ovary or to the oocytes results.[6] Millions of women have conceived normally after several years of ovulation suppression, and have given birth to normal children, so far. Most women who discontinue oral contraceptives return to their normal menstrual pattern within three months.[6] Some women may not ovulate for some time and some exhibit prolonged amenorrhea or acyclic bleeding. I have found no evidence that such a pattern could be attributed to contraceptive drugs. It should be recognized that some women already had these problems prior to drug therapy.[6] There are no studies correlating resumption of ovulation with type or duration of therapy.[9]

The menstrual cycle becomes standardized on the usual contraceptive regimen and breakthrough bleeding or amenorrhea appears more frequently in normal controls using vaginal contraceptives.[1]

The breast, another reproductive system target organ does not increase in average size, although some women claim mild hypertrophy; mastalgia is reported in less than 1% of women and does not increase over as many as 9 years of contraceptive use; lactation appears to be reduced by the higher dose preparations; and the frequency of breast nodularity is reduced which suggests inhibition of a potential precancerous state.[1] No increase in breast cancer has become evident.[10]

The other endocrine glands have revealed no serious functional abnormalities during or after oral contraceptive use.[1, 6] The pituitary is obviously depressed in some respects but resumes normal function after cessation of oral contraceptive therapy. This is clearly indicated by the practically immediate return of normal ovarian secretory activity and the almost hyper-normal fertility. Urinary output of luteinizing gonadotrophins is decreased, but human growth hormone secretion is elevated which may account for the diabetogenic effect of oral contraceptives.[1, 6, 10a]

The pituitary-adrenal feedback mechanism and adrenal function appear to remain normal, but changes occur in the excretion of 17-keto- and 17-ketogenic steroids, possibly related to an increase in the protein bound fraction of cortisol and changes in the intermediary metabolism of cortisol. Important to remember is that the urinary secretion of these steroids is decreased, sometimes to subnormal values, during anti-fertility therapy.[11]

Thyroid function remains normal in users of oral contraceptives and RAI uptake studies confirm this.[1] Measurements of protein bound iodine show a definite increase, frequently up to the hyperthyroid range. This is due to a characteristic estrogen effect, also seen during pregnancy, that increases the amount of thyroxin-binding-globulin in the blood.[1] It is very important to keep this laboratory side-effect of oral contraceptive in mind. Unusual thyroid vascularity has been reported in women on oral contraceptives who underwent thyroidectomies. It is suggested that contraceptive medication be stopped at least 2 months prior to surgery and large doses of Lugol's solution be used to decrease thyroid vascularity for at least one month.[5]

We now come to a number of effects or side effects of oral contraceptives that are more difficult to attribute directly to the drugs.[1] They are nausea, weightgain, mental depression, and changes in sexual activity, satisfaction, and response.[12] All of these symptoms are influenced by psychological factors. The information given by the physician who prescribes the drug is important.[1] Adequate studies are lacking. All I can say

is that a certain amount of nausea and weightgain due to fluid retention are seen with these drugs. For the great majority of women they do not represent a major problem.[13] Nausea tends to disappear after the first few cycles. According to some studies weightgain appears to be an all or none effect. It seems to occur in about one third of women who take oral contraceptives. Many women who complain about weightgain during use of the drug use the medication as an excuse and are actually overeating. Depression is not uncommonly seen in a young, overburdened housewife. There is no good evidence to support the view that depression results from the pharmacologic action of birth control pills. The patient eagerly blames the pills for her mood changes, thereby avoiding her own responsibility for her symptoms.[12]

There appear to be no bona-fide reasons to attribute changes in libido, sexual activity and satisfaction to the direct action of oral contraceptives. Again, so many psychological factors are involved, and so few adequate studies have been done, that it becomes difficult to make a qualified statement. Although the patient may blame the pill, it seems wise to look for other reasons for her complaints.[12]

Much attention has been devoted to alleged side effects of oral contraceptives that are potentially dangerous. And justifiably so. The most notorious possibility has been the increase in thromboembolic phenomena. Well documented, but not always unanimous, studies have shown that oral contraceptives tend to increase certain blood clotting factors, like fibrinogen, the vitamin K dependent factors (*prothrombin,* VII and X), factor VIII, platelet count, and antifibrinolytic activity. Most coagulation abnormalities during oral contraception tend to produce values in the so-called hypercoagulable range. These changes are similar to those seen during pregnancy, but occur to a lesser degree.[14, 15, 16] Some evidence has suggested that the rise in factor VII is cumulative.[17] Pulmonary infarctions, strokes, peripheral arterial occlusions, and even myocardial infarctions have been reported as possibly related to the use of oral contraceptives.[18–21] It is impossible to review in a short time span the careful statistical analyses that have been made, but a few points should be made clear.

There is unequivocal evidence that severe thromboembolic disease does occur in nonpregnant, apparently healthy, young women. The incidence rate is very low.[22] The conclusion that a demonstrable increase in certain clotting factors increases the risk of thromboembolic episodes is not justified on the basis of the available evidence.[15, 16] Also the commonly held belief that pregnancy increases the risk of thromboembolic disease is unwarranted. The incidence of thromboembolism during pregnancy compares favorably to that in the population at large.[22] Thromboembolic disease does increase towards the end of pregnancy and in relation to delivery and puerperium when there are numerous predisposing factors, such as bedrest, inflammation, damaged bloodvessels and the like.

In 1963 the so-called *Enovid* (Searle) Ad Hoc Committee (The Wright Committee) found no evidence that there was a significant increase in the risk of thrombo-embolic death from the use of *Enovid.*[23] This conclusion has been criticized, since it dealt only with mortality and not with morbidity. Basically the conclusion of the report still stands; it has been reviewed and expanded upon by others and found valid.[22] When an extremely unusual disease occurs in a young, healthy female one tends to look for a reasonable explanation. And how reasonable it is to attack the "pill." The reported incidence of thromboembolic morbidity in *Enovid* users varies from 20 (1963) to 50% (1962) of predicted idiopathic morbidity.[22]

Reviewing many articles it is impossible to escape the conclusion reached by the generally conservative editors of the *Medical Letter* that at this point a causal relation has not been established. "With millions of women using oral contraceptives, almost every known disorder must be expected to occur in some of the women."[2]

Nevertheless, I must admit that there are case reports in which it sounds extremely suggestive that there is a reasonable possibility of a relation between the onset of a thromboembolic episode and the ingestion of oral contraceptives.[18] A physician who withholds these drugs in a patient with an increased risk of developing phlebothrombosis certainly cannot be criticised. Increased risk factors are: a positive past history of deep thrombophlebitis, marked obesity, heart disease, trauma,

surgery, malignancy, and sickle cell disease.[24]

Changes in hepatic function probably are produced frequently by antifertility agents.[1, 25, 26] Most of the functional changes are transient and this is a reflection of adaptive mechanisms in the liver dealing with the increased metabolic load of drug-detoxification. It is estimated that in 10 to 40% of women increased BSP retention occurs which may gradually disappear in spite of continued drug administration. This is a known estrogen effect on liver function.[27] About one out of 10,000 women using oral contraceptives will develop jaundice. This can be due to three different processes: 1—an unusual sensitivity of the bile secretory apparatus to the hormones—this is seen in women who have had recurrent cholestasis of pregnancy; 2—a process similar to that seen with the anabolic steroids, causing a cholestatic type jaundice without evidence of hepatocellular damage; and 3—a situation where actual hepatocellular damage occurs and where a hypersensitivity of the liver cell is suspected.[25] All these reactions appear to be completely reversible upon discontinuation of the drug.[26] Jaundice or pruritus of pregnancy, congenital hyperbilirubinemia, and primary biliary cirrhosis are contraindications for the use of oral contraceptives. Opinion is divided as far as other liver ailments are concerned, such as liver-cirrhosis and a history of hepatitis. It seems safer to withhold the drug if there is any question about the functional integrity of the liver.[27]

I must mention, briefly, a few other important effects of oral contraceptives.

There are several good studies that show a significant decrease of glucose tolerance in women who take the "pill."[28] This effect is presumably due to the estrogen effect of the medication. The exact mechanism of action is unknown; it is well known that pregnancy in itself has a tendency to decrease glucose tolerance. It is possible that estrogens increase the plasma binding of insulin, thereby rendering it inactive; or estrogens may increase pituitary *ACTH* secretion thereby stimulating cortisol secretion or, estrogens may increase levels of human growth hormone which is diabetogenic. The last possibility has received reasonable support in recent studies.[10a] It is unknown whether the observed changes in glucose tolerance are damaging in themselves; it is known that 30 to 60% of women who exhibit abnormal glucose tolerance during pregnancy will develop permanent diabetes in 1 to 7 years. The abnormal glucose values in women on birth control pills may well serve as a good indication of so-called pre-diabetes. In one series 10% of the subjects had an abnormal fasting bloodsugar and 46% had an elevated 2 hour postprandial bloodsugar.

It should be stated here that there have been no reports of dramatic increases in cases of diabetes mellitus and that insulin requirements do not change in diabetics during oral contraceptive therapy.[6]

A second important metabolic change is the reported alteration of serum-tri-glycerides, total serum cholesterol, low density and very low density lipo-proteins in women taking oral contraceptives.[29] The changes observed produced a pattern resembling that seen in men. It is common knowledge that levels and distribution of serum lipids and lipo-proteins have been correlated with the incidence of atherosclerosis. Therefore, it seems justified to conclude that there is at least some evidence that oral contraceptives may accelerate the development of atherosclerosis. This is obviously an effect of which the ultimate results will only become known after many more years of observation.[4] As far as I have been able to determine it is the most incriminating effect of oral contraceptives. If these studies are confirmed and if the so-called atherogenic index has as much significance as has been claimed by some, oral contraceptives may well bring numerous women a little bit closer to their coronaries and strokes. This would be a most regrettable outcome.

A recent study alerts clinicians to a possible relation between the development or aggravation of arterial hypertension and the institution of oral contraceptive therapy.[30] This possibility is suggested by marked increases in blood pressure in a small group of women placed on birth control pills. An impressive increase was seen in renin-substrate concentration and its reactivity to exogenous renin which results in increased angiotensin production, as well as an increase in endogenous renin activity and aldosteron excretion. These changes were also seen in some normotensive women, therefore their significance in relation to the development of hypertension is not clear. The blood pressure came down to normal or improved markedly in 8 out of 11 women after

stopping the oral contraceptives. From this article it appears wise to discontinue these drugs in women who develop hypertension. It is also stated that in these cases one is probably dealing with an unusual group of patients, since there certainly haven't been many reports of this nature after a considerable experience with oral contraceptives in millions of women.

Finally, I shall mention in passing, side effects like increased facial pigmentation, hirsutism, vascular bruits, galactorrhea, dizziness, blurred vision, alopecia, and headaches.[1, 31] One can find them scattered through the literature in several reports. Adequate studies about their significance are lacking.[1]

The problem arises on how to handle a girl who walks into a doctor's office and wants a prescription for birth control pills?[4] Sir William Osler has said that one of the distinguishing features of man as opposed to other mammals is that he (or she) likes to take pills. It is always hard to talk a determined woman out of anything and many of the pill-users are quite determined, but I do try to talk them out of taking oral contraceptives. At the same time I try to be fair. The case against birth control pills should not be overstated and one doesn't help matters by scaring the patient. I tell her that there are excellent alternatives, and that she should certainly give those a try. The pill should be an acceptable, but a last resort, after all other methods are found unacceptable or impractical.[2] Then I insist on a complete history and physical examination. One should certainly think strongly about advising against the use of oral contraceptives if one finds a history of deep thrombophlebitis, migraine headaches, jaundice or pruritus of pregnancy, sickle cell disease, a marked family history of diabetes or arteriosclerotic complications. The physical examination should be entirely normal. The findings of an abnormal blood pressure, varicose veins, heart lesions, obesity, breast masses, pelvic abnormalities should delay the administration of oral contraceptives, often indefinitely.

If I can't find any good reason not to give the prescription I pick the combination of the lowest possible doses. It seems reasonable to assume that some or many of the side effects are dose related.[2] I tell the patient that I believe that the "pill" is safe on a short term basis, I explain that the subjective symptoms will probably disappear after the first few cycles, and that I do not believe that she can take the pill all of her fertile life without the possibility of hurting herself. I tell her to come back in 3, 6, and 12 months and thereafter at least once per year.

IN SUMMARY

Oral contraceptives have many physiological side effects, some of which are still being discovered and elucidated. There is no evidence that these side effects are either disturbing or harmful to the great majority of healthy females, if given on a relatively short term basis, say arbitrarily 5 years. Oral contraceptives are therefore a useful addition to the contraceptive armamentarium. There is insufficient information available about longterm deleterious effects and therefore a statement as to ultimate safety cannot be made by anyone.[2] The role of the physician is one of adequate discussion of the alternatives, proper screening of candidates, and reassurance as far as immediate health dangers are concerned, adding a word of caution about possible long term harmful effects.

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Beginning with the January 1968 issue of the Maryland State Medical Journal, there will be a Medicolegal Page written and edited by Belden R. Reap, Sr., MD, JD. It is hoped that this new feature will contribute to the continuing education of physicians, and cultivate in them a refreshed awareness of newer medicolegal trends, malpractice pitfalls in office and hospital practice, as well as recent and important court decisions. A very definite effort will be made to keep the content of the articles interesting. Questions will be answered promptly.

THE UTILIZATION OF TRAINED MILITARY PERSONNEL IN THE BALTIMORE HOSPITAL AREA

ARTHUR E. COCCO, MD
and
FLORENCE M. GIPE, RN, MS, EdD

The obvious need for paramedical personnel in this time of hospital staff shortage makes the question of proper utilization of trained paramedical personnel of paramount importance. This problem becomes even more obvious with the expansion of medical facilities, when such expansion is limited by insufficient personnel, thus, making the limiting factor of expansion *manpower deficit*. The question frequently asked is where can our medical institutions obtain adequate numbers of trained paramedical personnel? Similarly, it is asked are we doing all that is possible to properly utilize and attract interested and competent hospital personnel, especially those who give evidence of having certain knowledge and skill which are required to function successfully as a qualified medical assistant.

During the past five years various theories have been advanced in explanation of the shortage of trained paramedical personnel. These include: low pay, increased need for members of the health team as technical skills advance, increased numbers of hospital and health facilities, underutilization of available resources.

Since the Armed Forces of the United States employ and train large numbers of paramedical personnel this source eventually offers a potential supply of skilled workers for civilian use especially after discharge or retirement from military service. The purpose of this study was to learn if ex-military trained personnel are being utilized in medical institutions and what special factors limit their employment.

PROCEDURE OF STUDY

Questionnaires were sent to twenty-two hospital registered nurse directors of nursing service who employed registered nurses, licensed practical nurses, leaders and subleaders of the nursing care personnel team as well as members of the paranursing care group. The following is a sample of this questionnaire:

1. Do You Employ?
   a. Trained male aides
   b. Discharged military corpsmen
2. Do You Employ Discharged Military Corpsmen Under the Title As?
   a. Orderlies
   b. Assistant nurses
   c. Medical and surgical technicians
   d. By what other title do these classifications appear in your personnel office?
3. How Do Discharged Military Corpsmen Compare To Other Ancillary Male Employees In Nursing?
   a. Inferior
   b. Equal ability
   c. Superior
4. Are All Ancillary Male Personnel In Nursing Paid the Same Salary Regardless of Their Past Training and Experience and the Work They Perform?
   Do not state salary, only note differential between an orderly and
   a. Military corpsmen
   b. Men assistant nurses
   c. Medical and surgical technicians (who assist in O.R.)
   d. Men nurse aides or attendants

5. What Are the Educational Requirements of?
   a. Military corpsmen
   b. Medical and surgical technicians
   c. Attendants
   d. Orderlies
6. Do You Consider Educational Preparation and Requirements When Employing These Ancillary Personnel?
7. Are Educational Benefits Offered to Paramedical Personnel Employees Such as Further Opportunities With Pay for Education to Do A Better Job?

RESULTS

Twenty-one hospitals out of the twenty-two hospitals which were sent questionnaires responded. Of these, eighteen hospitals reported that during the past they had employed at some time or another personnel who were trained in the army. Of these eighteen representative hospitals all but one expressed the opinion that military trained personnel were superior in every aspect. Such male personnel had been employed with a specific title such as:

1. Medical or surgical technician
2. Assistant nurse
3. Male aide
4. Orderly

Of the entire group reported 93% were classified as orderlies. The remaining number were classified in the other listed categories. Two directors of nursing stated that no military corpsmen had ever applied for work in their hospital. One hospital reported that a number of military corpsmen had been employed but only two remained for periods of time longer than one year. The basic explanation for this turnover was that the salary was too low. Differences in salary for trained military personnel versus untrained personnel ranged from ten cents per hour to two dollars per week. Only one hospital paid trained military personnel as high as ten dollars per week more than inexperienced paramedical personnel. In none of the hospitals was there a separate classification for trained and experienced military corpsmen. The bulk of the hospitals still carried these trained and experienced personnel on the hospital payroll as orderlies.

All hospitals except four stated they require some high school training as a prerequisite for employment. The state hospitals in Maryland and several private institutions were emphatic stating that high school graduation was mandatory. It was learned that the bulk of military personnel were high school graduates and many had actually completed some college credits when located in the army. Although some emphasis on education is made by nearly all medical institutions, none of the hospitals offered civilian educational benefits other than those concerned with special medical or nursing techniques and procedures. In no hospital was clinical experience in allied nursing specialties for army corpsmen given due consideration. The clinical experience of army personnel presently being utilized averaged from five to twenty-one years while clinical experience for civilian workers averaged less than one year. In many of the hospitals nursing service department studies, it was learned that specific job analysis for each classification of worker was or had been utilized and it was apparent that in most instances ex-military personnel were assigned work of higher quality and responsibility and that his performance of such skills and techniques were usually of a higher quality than that of non-military personnel. In one large hospital, military corpsmen were not allowed at the bedside with other "sub-professionals." This hospital director of nurses was of the opinion that ex-military personnel should be utilized only in operating rooms, emergency accident rooms, in outpatient clinics and intensive care units.

DISCUSSION AND FURTHER CONCLUSION

Personal communication with the US Surgeon General revealed that approximately 12,000 paramedical personnel are separated from the Army each year. (Figures are not available for other branches of the service nor are figures available relative to the number released yearly to the Maryland area.) These people (ex-army corpsmen) were informed and advised of hospital and clinic employment opportunities provided by local State Employment Offices. This counseling is done by representatives of the Veteran's Employment Service of the US Department of Labor in cooperation with and working through the local State Employment Service Offices, which maintains information for veterans as to the types of available employment in public works and private industry. There is no authoritative "medical organization" either on a national or state level actively pursuing and aiding placement of this impor-

tant body of personnel. Personal communication with some paramedical personnel trained in the army who are presently working in civilian hospitals in Baltimore revealed that none were directed to their present positions by any of the aforementioned agencies.

Since discharged military personnel are hired in civilian hospitals as orderlies, the low salaries commensurate with this position seems to be the major deterrent toward the continuation of this occupation in civilian life. As with most who work in the health field the occupational stimulus is strong. Most people, however, agree that this stimulus is not sufficient to overcome the grossly inadequate income benefits. This deficit is further potentiated by the lack of recognition in civilian hospitals of experience gained in the army. This lack of recognition seems the result of societies and organizations issuing licenses to allied health personnel in technical specialties. These groups frequently place great emphasis on educational requirements in an effort to insure high quality (an admirable goal), and give no recognition to practical experience or training obtained in military schools. Admittedly many of these people have served sufficient time in the military to be eligible for military retirement programs, and therefore may not require excessive salary committments. Even so, the present wage offered seems so far out of line with the current standard that the impossibility of raising and educating a family are obvious. Do these important people and their families deserve less?

SUMMARY

From what has been learned from the Nursing Service Directors, and personal contact with discharged military paramedical personnel, it appears that the services of well trained ex-military paramedical personnel are not available to hospitals because:

A. No organized effort is made by *organized medicine* to channel this manpower flow into needed areas.

B. Low salaries. Military personnel have openly asserted their preference for work in hospitals and clinics, but that the pay is not a living wage.

C. Low status or lack of worthwhile recognition. This is in part the result of demanding licenses for various levels of health workers without due consideration for military training or experience.

The solutions to these problems are obviously complicated and multi-faceted. Many groups will offer support and opposition to each detail and in accord with the past, disagreement will be prominent. If these problems are to be solved, however, in accord with standards required by the physicians who are responsible for patient care, active pursuit by all is not only important but is highly and immediately necessary.

PHYSICIAN UTILIZATION BY INNER CITY RESIDENTS OF BALTIMORE

HENRY W. D. HOLLJES, MD
Medical Care Services, Baltimore City Health Department
and
HELEN B. FREEDMAN, BA
Senior Public Health Analyst, Medical Care Services, Baltimore City Health Dept.

From 1948 to 1963 Baltimore City provided a Medical Care Program for indigent people on a capitation basis.[1] A change to a fee-for-service payment took place in 1963 as reviewed by Rodman[2] who observed a 10% increase in the physician utilization rate; Alexander[3] indicated that such an increase was to be expected. The Baltimore City Medical Care Program ceased to exist after June 30, 1966 and was replaced on July 1, 1966 by the Maryland Medical Assistance Program (*MAP*).

MAP continued the fee-for-service payment system but substantially increased the eligible population through the addition of medically indigent individuals under 65 years. Furthermore, the seven hospital sponsored medical care clinics that existed under the old program terminated their operations. Public medical care recipients are now free to go to any hospital outpatient clinic or any private physician for medical care.[1] The effect that these changes have had upon the inner City of Baltimore was studied by the Baltimore City Health Department.

In order to determine the immediate impact of the new program during the Spring of 1967, one thousand households were surveyed in economically deprived areas in Baltimore City.[4] This survey attempted to assess how disadvantaged people were using existing medical services. Also, the extent of enrollment in the new program was determined in the ten census tracts sampled. The pattern of medical services utilization was compared between those enrolled in *MAP* and those not covered by *MAP*. At the time that the household survey was conducted, hospital outpatient departments were reimbursed 100% of cost and the Medical Assistance Program fees-for-service to physicians were as follows: $3.50 office call, $4.00 home day call and $4.50 home night call.

The object of this communication is to describe the major findings of the household survey and compare some of these with the previous medical care program.

OBSERVATIONS

Household Population Characteristics—4,379 individuals were interviewed, an average of 4.4 persons per household. In 450 households (45.0%), the head was reported as a female. In 515 households (51.5%) some or all members were reported to have *MAP* Identification Cards. Households with members on *MAP* were significantly larger (median—3.7 members) and younger (average age of 25 years) than those households without *MAP* members (2.7 and 39 years respectively). Individuals in households on *MAP* reported a significantly higher incidence of illness than those not on *MAP* (11.4% vs. 8.7%).

Utilization of Physicians' Services—Of individuals who reported that they were not only ill but in addition visited a physician, a significantly larger percentage was found in the group on *MAP* (8.4%) as contrasted with the group not on *MAP* (5.8%). Furthermore, 38.8% were attended by their neighborhood physician either at their home or at his office; 56.2% utilized the medical

Diagram 1

UTILIZATION RATES BY INDIVIDUALS IN TWO WEEKS PRIOR TO DATE OF INTERVIEW
BY AGE AND SEX

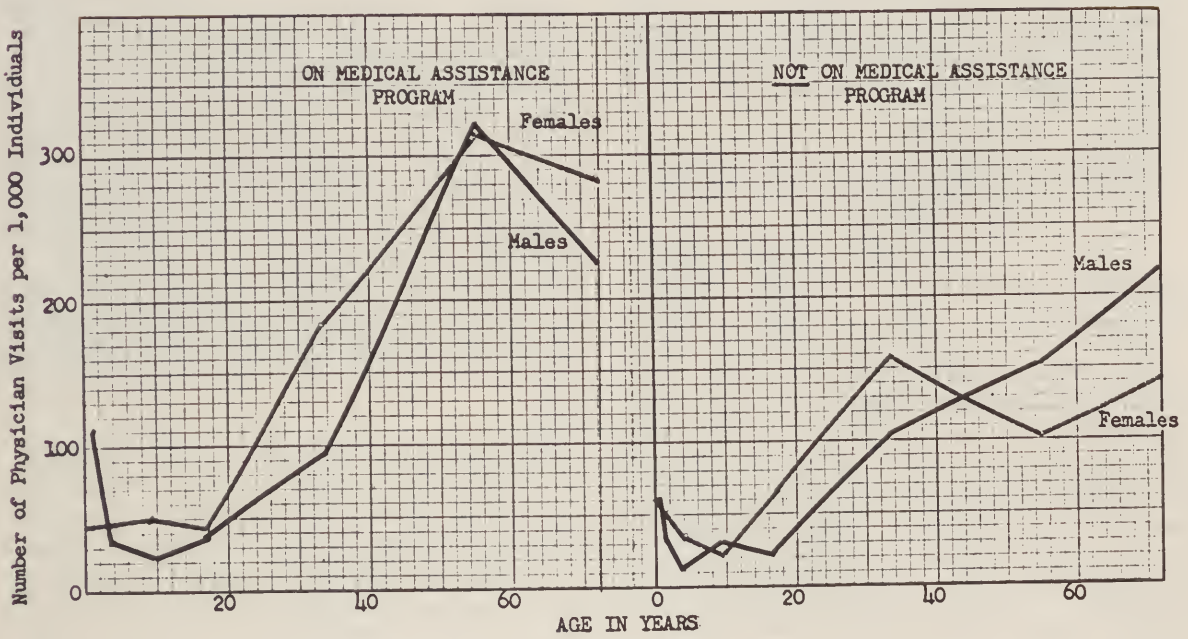
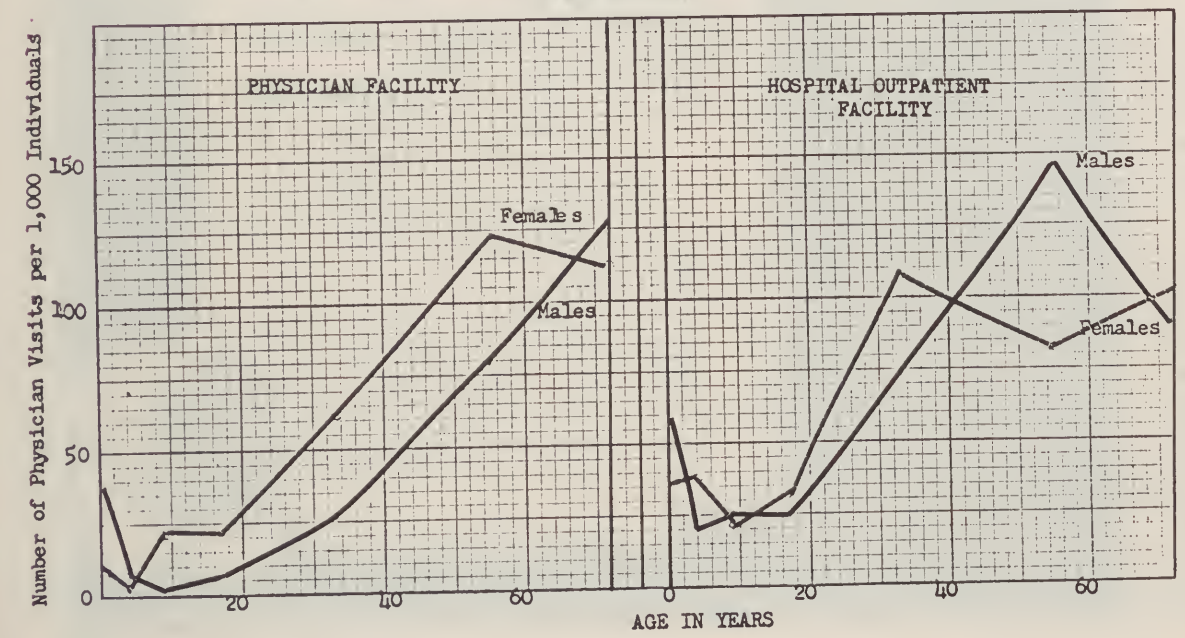


Diagram 2

UTILIZATION RATES BY INDIVIDUALS IN TWO WEEKS PRIOR TO DATE OF INTERVIEW
BY AGE AND SEX



services of a clinic or outpatient facility; and 5% went to both. This pattern of seeking medical care indicates an apparent reversal of the trend in physician utilization for Baltimore City during 1963 as reported by the National Health Survey of 1964,[5] and by a 20% random sample of individuals on the Baltimore Medical Care Program in 1966.[6] A comparison of these trends is presented in tabular form.

Physician and Hospital Clinic Utilization Rates (Percent)

	1963-1964[5]	1966[6]	1967
Physician Services	61.9	57.8	38.8
Hospital Clinics	18.7	42.2	56.2

Age Specific Rates—For all households sickness was reported more frequently among individuals aged 65 and over (217.8 per 1,000 individuals). For the households with *MAP* members, individuals 45-64 years of age had a higher incidence of illness (265.5 per 1,000). Similarly the number of persons who used physicians' services was higher in the group 65 and over (166.2 per 1,000). However, when rates were computed separately for those on *MAP* and not on *MAP*, individuals on *MAP* between 45-64 had a higher usage (224.2 per 1,000). This corresponds to the utilization rates computed from data on the Baltimore City Medical Care Program for the year ending June 30, 1966. *MAP* patients aged 45-64 years, both males and females, utilized physicians' services to a significantly higher ($p<.001$)* extent than people not on *MAP* (diagram 1). In this age group females predominantly used private physicians' services while males preferred hospital outpatient facilities (diagram 2).

DISCUSSION

Since the total population served by *MAP* is much greater than that on any previous Baltimore City medical care program, the total number of services provided by private physicians also appears greater. A projection of this household survey supports this view while it provides even greater expansion of hospital outpatient services. In short, more paid patient services are being provided by both private physicians and hospital clinics since the establishment of *MAP*. As neither the number of private practitioners nor the number of public service hospital facilities has increased appreciably in Baltimore during the past ten years, the increase in the number of paid services indicates that *MAP* has had a decided effect by increasing the productivity and remuneration of both physicians and hospital facilities.

The expansion in hospital outpatient services may be related to the *MAP* provision that allows 100% cost reimbursement. Private physicians participating in *MAP* are reimbursed on a fee schedule noted above. Before *MAP* the hospitals of Baltimore complained that the capitation rate under which they were paid fell short of expenses which were incurred directly by patients and by referral of patients from neighborhood physicians.

The response of the hospitals to cost reimbursement for fees and charges as well as the response of the physicians to fixed fees were not measured in this survey but may be reflected in the utilization of services. Whereas, hospitals formerly incurred deficits as the utilization of their services increased beyond the maximum capitation rate, they now receive more adequate compensation. The response of private physicians to fixed fees could have resulted in greater individual physician productivity as noted in *A Report To The President: Medical Care Prices.*[7] With the advent of *MAP*, more physicians' services and more hospital services appear to be utilized by a greater number of patients than under any previous program in Maryland.

The apparent reversal of the trend in physician utilization may indicate an insufficient growth in the number of neighborhood doctors within the area to serve the needs of the patients, with the result that medical care is more readily available in the hospital outpatient department nearest them.

Middle-aged *MAP* patients stated a higher rate of visits for physicians' services than middle-aged patients not on *MAP*. Presumably, this is secondary to a higher incidence of chronic disease and disability of persons on *MAP*. Those individuals not on *MAP* were healthier and more productive and for these reasons were less likely to be in need for medical assistance.

The sex differences noted are more conjectural. Perhaps the nature of the illnesses of males 45-64

*The probability of this difference occurring by chance is less than one out of a thousand and therefore highly significant.

on *MAP* is such that specialty clinics at hospitals are better able than neighborhood physicians to provide care while with the females of this group the reverse is true.

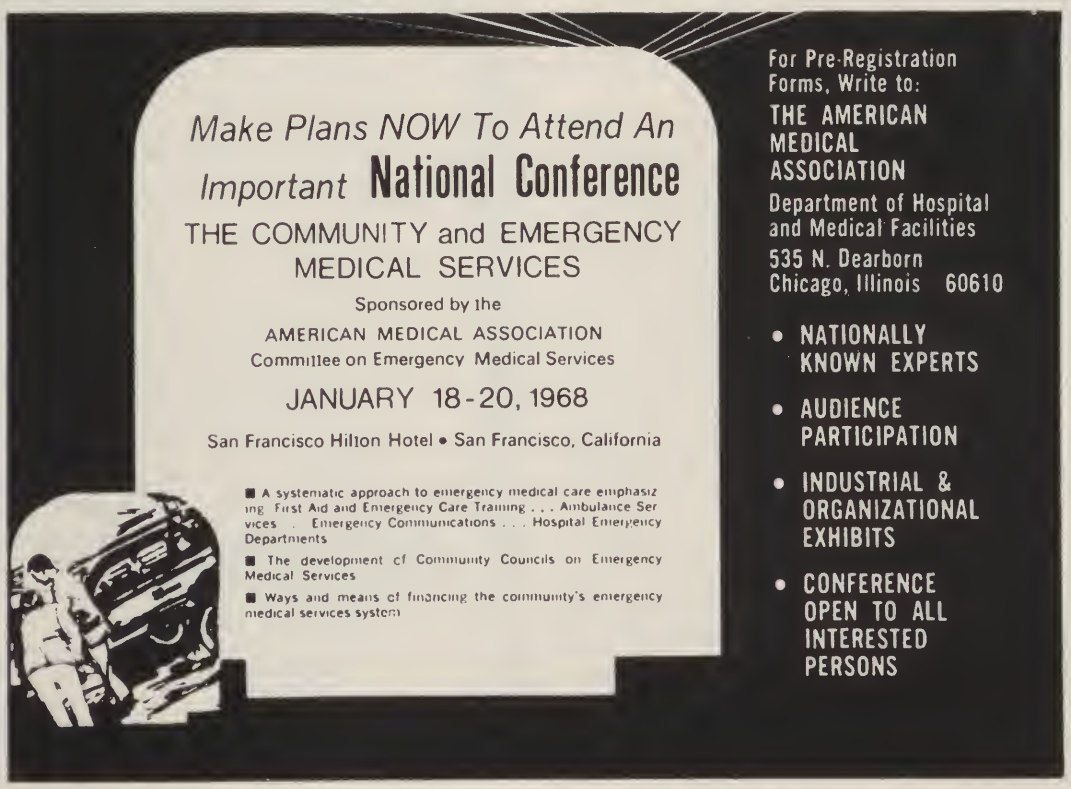
In summary the Maryland Medical Assistance Program is effecting greater utilization of private physicians' services as well as hospital outpatient services than any previous similar program, according to the household survey conducted by the Baltimore City Health Department. There is a strong indication that both men and women 45-64 who are on *MAP* are in poorer health than people of that age who aren't on the program. Certain medical economic factors, including the more liberal payments for outpatient services to hospitals, the probability of increased productivity on the part of physicians, and the apparent need for more neighborhood physicians are noted.

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Acknowledgement

The authors gratefully acknowledge the help of Martin K. Gorten, MD, Director of the Medical Care Services Section of the Baltimore City Health Department, for his suggestions in the design of the study and upon review of the manuscript, for his suggestions for its improvement. Also, we wish to thank the staff of the Medical Care Services Section for their assistance in the tabulation of the study and in the preparation of the manuscript.



DRUGS—JUDGMENT OR REGULATION?

As with many important issues today the subject of so-called "generic dispensing" is clouded with a great number of confusing and conflicting statements.

Generic prescribing is not new and has been an integral part of prescribing for many, many years. A drug usually has three names: a chemical name, which has significance primarily to the chemist and other scientists; a generic or public name, which is somewhat simpler and has greater understanding in pharmacology, medicine, and pharmacy; and a trade or brand name which conveys information as to the manufacturer of a particular product. Thus for particular generic drug entities there may exist different brand names, connoting a difference in the method of manufacture, controls at different levels of production, and a history of clinical performance characteristic of *that particular brand.*

A pharmaceutical product is more than a drug, and the care, skill and integrity employed in its manufacture may make all the difference in the performance of that product in a patient. There are those who would have us believe that all products containing the same generic drug are therapeutically identical but this is not true. The Commissioner of the Food and Drug Administration in recent testimony and speeches has clearly indicated that although he might like to give the assurance that all drug products are clinically equivalent, at this point in time he cannot honestly do so.

A great deal has been made of the fact that the government buys drugs under generic names only. However, if one examines the bid awards, one finds that an overwhelming majority of products are supplied by brand name manufacturers. In a recent speech, a representative of the Defense Personnel Support Center indicated, "Basically, our problem is this: chemically equivalent items are not necessarily stable, therapeutically equivalent products . . . 45% of the pre-award samples submitted by the low bidder last year failed to pass our tests."

The truth of the matter is that the technology of understanding drug action, availability, absorption, excretion, binding, partition coefficient, solubility, enzymatic interaction and a host of other factors is still in its infancy. These are more than mere technical characteristics; they are determinants of therapeutic performance. Thus the history of *experience* by the physician and pharmacist and the integrity of the producer to produce drugs which result in consistently reproducible action is the most reliable guide available at this time. Any effort to remove the prescription decision from the physician and substitute some government constituted authority, is a dangerous proposal which could be detrimental to the health of the patient and a serious blow to high quality medical care in this country.

The number of products for which generic prescribing might result in savings for the patients represent less than 20% of the total number of prescriptions dispensed annually. In some of these instances the real savings are relatively insignificant. The proposed savings that are supposedly available have been wholly exaggerated. In the majority of instances of generic prescriptions, it has been the policy of most pharmacists to dispense only those products which experience has shown to be therapeutically reliable—generally a branded product.

The physician, who has the ultimate responsibility for the treatment of the patient, should be constantly aware of the drug products *prescribed* and *dispensed* for his patients. He can on occasion, by consulting with his pharmacist, select

* The author wishes to remain anonymous.

products in which a degree of confidence can be assured with some cost savings resulting. However, an understanding of all parameters involved is essential. There have been too many instances where patients on maintenance therapy with such drugs as anticoagulants are hospitalized; products of different manufacture are supplied and results have been disturbing and even life-threatening.

Regardless of the advancement of our scientific information, a great deal of the practice of medicine and of pharmacy involves the use of professional judgment. Any artificial barriers which interfere with the exercise of this judgment are unwise and dangerous. The physician should be free to prescribe the products which he deems best for his patients. Any changes in the medication should only come about after proper consultation between physician and pharmacist and only effectuated with the consent of the physician. Those who seek other approaches should make certain that they are fully aware of the consequences that may result and determine whether the risks involved are truly worth the savings. In the best interests of public health, we do not believe that they are!





DIAGNOSTIC PROCEDURES IN GASTROENTEROLOGY, Charles H. Brown, MD; The C V Mosby Company, St. Louis.

This book fills the need for a manual to aid Roentgenologists and others in connection with special diagnostic tests and procedures in the area of gastroenterology.

The procedures are presented in an outline form rather than in detail. Much emphasis is placed on gentleness in the handling of patients. In essence, this book is a good reference and will enable the physician to avoid mistakes that are time consuming and potentially hazardous to the patient.

SYNOPSIS OF GYNECOLOGY, Daniel Winston Beacham, MD, Woodard Davis Beacham, MD; The C V Mosby Company, St. Louis.

This synopsis is intended primarily for students who do not intend to pursue gynecology as their chosen field. It is intended as supplemental to the larger textbook and can be used for study at odd moments and memorization of the leading points in gynecologic examination, diagnosis and treatment. The practicing physician will also find it extremely helpful as a guide to the understanding of pelvic disturbances he may encounter or as a compact presentation of the outstanding features of this interesting department of medical knowledge.

MEDICAL LICENSING IN AMERICA, 1650-1965, Richard Harrison Shryock, The Johns Hopkins Press.

This somewhat small publication of a little over 100 pages devotes itself to two subjects and two eras involving medicine. The subjects cover "Problems and Procedures in Licensing 1900-1965;" and "Conclusions." The eras are the periods of 1650-1875 and 1875-1965.

The conclusions reached are not earth-shaking but, in fact, commend the medical profession in its approach "Towards perfection which has actually been attained."

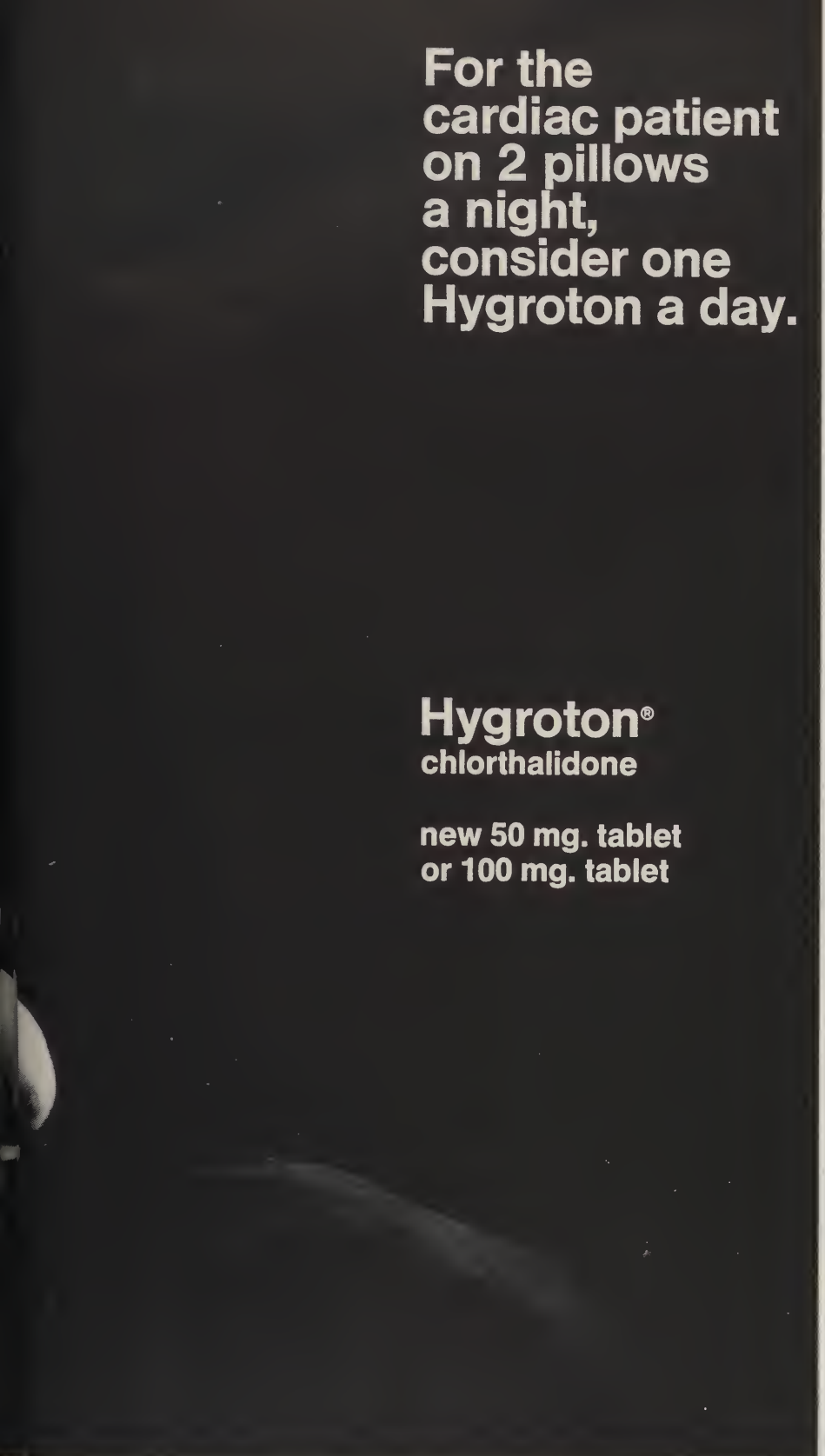
NEUROPSYCHIATRY IN WORLD WAR II, VOLUME I; Office of the Surgeon General, United States Army Medical Service, Washington, DC.

Battle experiences clearly demonstrate that combat psychiatric breakdown can originate from normal or previously stable personnel, as well as from those of greater vulnerability. During WW II, the Army Medical Department was confronted with the difficult task of dealing with an unprecedented incidence of psychiatric casualties for which there had been little preparation. The struggle to overcome these handicaps and the eventual establishment of effective programs of prevention and treatment are all presented in this 826 page volume.



Indications: Hypertension and many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.
Use with caution in pregnant patients, since the drug may cross the placental barrier and adverse reactions which may occur in the adult (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.
Precautions: Antihypertensive therapy with Hygroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol may potentiate hypotension. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.
Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Hygroton should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.
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For the cardiac patient on 2 pillows a night, consider one Hygroton a day.



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Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.
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BUSINESS SESSIONS

SPECIAL MEETING

November 11, 1967

MINUTES

The 259th meeting, special session, of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland was called to order at 2:00 p.m., Saturday, November 11, 1967, at the Faculty Building, 1211 Cathedral Street, Baltimore, Maryland, the President and Secretary being present.

The following delegates (or alternates) were registered as being in attendance. An asterisk indicates an alternate delegate.

Doctors: Manning W. Alden, Council; Robert G. Angle, Montgomery County; *Charles Bagley III, Wicomico County; Timothy D. Baker, Baltimore City, John G. Ball, Montgomery County; Edward M. Barczak, Baltimore City; Richard D. Bauer, Council; Harry McBrine Beck, Baltimore City; Donald W. Benson, Baltimore City; M. McKendree Boyer, Past President; Douglas G. Carroll, Baltimore City; Robert G. Chambers, Baltimore City; *Katharine A. Chapman, Montgomery County; Henry V. Chase, Council; Archie R. Cohen, Council; H. Douglas Cooper, Wicomico County; William B. Culwell, Carroll County; Worth B. Daniels, Jr., Baltimore City; Henry V. Davis, Cecil County; John B. De Hoff, Baltimore City; DeWitt E. DeLawter, Montgomery County; *F. Mark Dugan, Baltimore City; J. Sheldon Eastland, Council; William Carl Ebeling, Council; Vincent J. Fiocco, Carroll County; Whitmer B. Firor, Past President; Russell S. Fisher, Council; Harold H. Gist, Washington County; Paul F. Guerin, Council; William B. Hagan, Council; John S. Haught, Prince George's County; William G. Helfrich, Baltimore City; Thomas F. Herbert, Howard County; Philip W. Heuman, Harford County; Frederick M. Johnson, Charles County; Ferd E. Kadan, Baltimore City; James R. Karns, Baltimore City; Lauriston L. Keown, Baltimore City; Edward L. J. Krieg, Baltimore County; C. Rodney Layton, Queen Anne's County; Herbert H. Leighton, Garrett County; Thomas F. Lewis, Allegany County; William J. McClafferty, Baltimore City; George S. Malouf, Prince George's County; Karl F. Mech, Council; Walter C. Merkel, Board of Medical Examiners; B. Martin Middleton, Council; Donald W. Mintzer, Baltimore City; G. Allen Moulton, Jr., Allegany County; Frederick E. Musser, Prince George's County; Clayton Norton, Anne Arundel County; Sidney Novenstein, Washington County; Charles F. O'Donnell, Council; Hilary T. O'Herlihy, Anne Arundel County; William A. Pillsbury, Jr., Council; J. Emmett Queen, Council; Belden R. Reap, Sr., Montgomery County; J. Morris Reese, Council; Guy M. Reeser, Jr., Talbot County; Thomas R. Reid, Frederick County; Paul F. Richardson, Baltimore City; Peter W. Rieckert, Dorchester County; *James A. Roberts, Montgomery County; Raymond C. V. Robinson, Baltimore City; Salvador Rossello, Baltimore City; Edwin Ruzicka, Talbot County; John F. Schaefer, Council; Emmanuel Schimunek, Baltimore City; Arthur G. Siwinski, Council; R. Kennedy Skipton, Prince George's County; *Gordon M. Smith, Montgomery County; Aaron C. Sollod, Baltimore City; Martin E. Strobel, Baltimore County; E. L. Suarez-Murias, Baltimore City; Aaron H. Traum, Montgomery County; Thomas E. Van Metre, Jr., Baltimore City; Merton T. Waite, Anne Arundel County; Emerson C. Walden, Baltimore City; William C. Weintraub, Prince George's County; Lawrence R. Wharton, Jr., Baltimore City; Daniel Wilfson, Jr., Baltimore City; Charles H. Williams, Baltimore County; Ralph H. Williams, Washington County; Donald O. Wood, Baltimore County; Charles E. Wright, Frederick County; John D. Young, Jr., Baltimore City; Raymond M. Yow, Council.

Staff personnel were also present for the meeting.

* Alternate delegate.

ANNOUNCEMENTS

The President made certain announcements with regard to the conduct of business at the session.

SUBSTITUTE PROPOSAL

John M. Dennis, MD, Chairman of the Ad Hoc Committee on Changes in the Medical Practice Act, reporting on its behalf, recommended that the amendment to strike out "Commission" and insert "Board of Medical Examiners" wherever it appeared, which was pending when the proposed act was recommitted, be rejected, and that the proposed act be then amended by the substitution of a revised proposal submitted by the Committee.

GENERAL DEBATE

General debate followed during which Walter C. Merkel, MD, president of the board of Medical Examiners, and John F. King, Esquire, Counsel for the Faculty, among others, spoke.

PENDING AMENDMENT REJECTED

Thereupon, the House rejected the amendment to strike out "Commission" and insert "Board of Medical Examiners" wherever it appeared, and proceeded to a seriatim consideration of the substitute proposed by the Committee. After debate and amendment, the proposed substitute was agreed upon, and the chair put the main question, as amended,

SUBSTITUTE ADOPTED AS AMENDED

"That the following proposed statute be adopted with the understanding that it is to serve as a guide to our representatives at the Legislature in Annapolis."

The text of the proposed statute as adopted is as follows:

PROPOSED COMMISSION ON MEDICAL DISCIPLINE

The Commission on Medical Discipline of Maryland, hereby established and hereafter referred to in this Chapter as the Commission, shall consist of the following persons:

The President of the Medical and Chirurgical Faculty of the State of Maryland

The Immediate Past-President of the Medical and

Chirurgical Faculty of the State of Maryland

The President-elect of the Medical and Chirurgical Faculty of the State of Maryland

Two Practicing Physicians appointed by the Governor of the State of Maryland selected from a list submitted by the Medical and Chirurgical Faculty of the State of Maryland such list having been composed from a list of nominees submitted by Component Societies of the Medical and Chirurgical Faculty

Three Members of the Board of Medical Examiners to be selected by said Board of Medical Examiners

The Chairman of the Council of the Medical and Chirurgical Faculty of the State of Maryland

Seven of the nine members of the Commission shall constitute a quorum for the transaction of all business.

The Commission may establish and maintain an office within this State and shall make, adopt and promulgate rules and regulations for its own government and for the proper supervision and control of the professional conduct of all persons under its jurisdiction as provided herein and not inconsistent with the laws of this State or of the United States.

There shall always be nine members and no person shall serve in a dual capacity. In the event of such occurrence, the Governor may designate a practicing physician from a list submitted by the Medical and Chirurgical Faculty of the State of Maryland, such list having been composed from a list of nominees submitted by Component Societies of the Medical and Chirurgical Faculty.

(a) *Terms of Office:* The terms of office for appointees shall be for three years or until his successor is duly elected, appointed or qualified. Terms of office shall be from the 1st of July each year, except when the initial appointments are made; such appointments will be for staggered terms so as to provide for continuity on the Commission.

(b) *Reports:* The Commission shall make annual reports to the Governor, the Board of Medical Examiners and to the Medical and Chirurgical Faculty of the State of Maryland.

(c) *Removal of members:* Any member of the Commission may be removed by the Governor for cause.

(d) *Compensation:* Members of the Commission shall receive no salary but may be reimbursed for actual expenses incurred in connection with their official duties with the Commission.

(e) *Duties and Obligations:* The Commission shall refer any cases coming to its attention to the appropriate Committee of the Medical and Chirurgical Faculty of the State of Maryland for investigation and report. The report shall be acted upon within 90 days unless given a time extension by the Commission and shall contain such recommendations as the investigation reveals might be necessary for adequate disciplinary procedures. Such recommendations will then be considered by the Commission which will take whatever action it deems appropriate, as provided herein.

The Medical and Chirurgical Faculty of the State of Maryland may initiate action by virtue of information coming to its attention from its own members or through any other source, such cases being handled in the same manner as though they had been referred to it by the Commission.

(f) *Power and Duties:* When the Commission has completed its investigation according to the process outlined herein, it shall have the power to reprimand, place on probation, revoke, or suspend the license or dismiss the charges against any licensed physician for any of the causes listed below as unprofessional conduct but such action shall not be limited to these causes:

1. Fraudulent or deceptive procuring or use of a license.
2. Solicitation or advertising contrary to Article 43, Section 146 of the Annotated Code of Maryland.
3. The performance of a criminal abortion.
4. Conviction for, or plea of nolo contendere to, a crime involving moral turpitude.
5. Abandonment of a patient.
6. Addiction to narcotics, habitual drunkenness or rendering professional services to a patient if the physician is intoxicated or under the influence of drugs.
7. Promotion by a physician of the sale of drugs, devices, appliances or goods provided for a patient in such a manner as to exploit the patient for financial gain of the physician.
8. Immoral conduct of a physician in his practice as a physician.
9. Willfully making and filing false reports or records, in his practice as a physician.
10. Willful omission to file or record, or willfully impeding or obstructing a filing or recording, or inducing another person to omit to file or record medical reports required by law.
11. Failure to furnish details of a patient's medical record to succeeding physicians or hospital upon proper request.
12. Solicitation of professional patronage by agents or persons, or profiting from the acts of those representing themselves to be agents of the licensed physician.
13. Division of fees or agreeing to split or divide the fees received for professional services with any person for bringing to or referring a patient.
14. Willful misrepresentation in treatments.
15. Practicing medicine with an unlicensed physician except in an accredited preceptorship or residency training program; or aiding, abetting such unlicensed persons in the practice of medicine.
16. Gross and willful and continued overcharging for professional services; including filing of false statements for collection of fees for which services are not rendered.
17. Offering, undertaking or agreeing to cure or treat disease by a secret method, procedure, treatment or medicine.
18. Revocation of license by any other state or territory for any cause whatsoever.
19. Professional or Mental Incompetency.

(g) *Immunity from Suit:* All persons acting as members of authorized committees of the Medical and Chirurgical Faculty of the State of Maryland and its component societies or as the Commission shall be immune from suit in any action, at law or equity, based upon any disciplinary proceedings or other official acts in the furtherance hereof and performed in good faith.

(h) *Subpoena:* The Commission shall have the power to issue subpoenas and administer oaths in connection with any investigation, hearing or proceeding.

(i) *Hearing and attorney rights:* Any physician who shall have a case referred to the Commission on Medical Discipline shall have the opportunity to appear in person before the Commission at a hearing duly convened, at which time he shall have the right to be represented by counsel and all proceedings of the Commission shall be subject to the provisions of the administrative procedures act.

(j) *Certificate of revocation, suspension or reprimand.* If a majority of a quorum of the members of the Commission vote in favor of finding the accused guilty of unprofessional conduct as specified in the charges, the Commission shall prepare written finding of fact and may thereafter prepare and file in the office of the Board of Medical Examiners a certificate or order of revocation, suspension or reprimand in which case notice thereof shall be served upon the accused forthwith.

(k) *Dismissal of charges—Exoneration.* If the license holder is found not guilty, the Commission shall forthwith order a dismissal of the charges and the exoneration of the accused, and no further action may be taken by the Commission on the charges involved.

(l) *Revocation or suspension of license—Stay pending review.* The filing by the Commission in the office of the Board of Medical Examiners of a certificate or order of revocation or suspension, after due notice, hearing and findings in accordance with the procedure specified in this chapter, certifying that any holder of a license has been found guilty of unprofessional conduct by the Commission shall constitute a revocation or suspension of the license to practice medicine and surgery in this state in accordance with the terms and conditions imposed by the Commission and embodied in the certificate or order of revocation or suspension. If the licensee seeks judicial review of the Commission's decision pursuant to the provisions of this chapter, such revocation or the period of such suspension shall be stayed and shall not be effective or commence to run until final judgment has been entered in any proceeding instituted under the provisions of this chapter and the licensee's judicial remedies exhausted hereunder.

(m) *Contents of certificate—Recording.* The certificate or order of revocation or suspension shall contain a brief and concise statement of the ground or grounds upon which the certificate or order is based and the specific terms and conditions of such revocation or suspension, and shall be retained as a permanent record by the Board of Medical Examiners as well as by the Commission.

(n) *Issuance of license after revocation or suspension.* The Board of Medical Examiners shall not issue any license or any renewal thereof to any person whose license has been revoked or suspended by the Commission except in conformity with the terms and conditions of the certificate or the order of revocation or suspension, or in conformity with any order of reinstatement issued by the Commission or in accordance with the final judgment in any proceeding for review.

(o) *Appeal from decision by Commission.* Any person whose license has been revoked or suspended by the Commission, or if said person is placed on probation, or reprimanded he shall have the right to a judicial review of the Commission's decision. He may enter an appeal to the Circuit Court of Baltimore City or in the Circuit Court in the County in which the charges originated or in which the physician maintains his principal office and serve notice of said appeal on the Commission within 30 days after the filing of the certificate or of the revocation, suspension, probation or reprimand. All parties, including the Commission, shall have the right of further appeal to the Court of Appeals of Maryland.

* * * * *

Reference is made to this section in the Proposed Commission on Medical Discipline, under "f" (2)

No physician shall advertise except in the following manner:

(a) A physician may use a personal professional card not larger than three and one-half inches by two inches, upon which may be printed his name, title, address, specialty, telephone number and office hours and nothing else.

(b) A physician may send removal notices to any of his bona fide patients or to any other physician, notifying them that he is removing his offices from one address to another. Such notices, upon which may be printed his name, title, specialty, telephone number, office hours, residence and business addresses, information necessary to indicate the removal of offices and nothing else, shall not be larger than five inches by seven inches.

(c) A physician may send to any other physician of his choosing an announcement that he has opened an office or changed the professional composition of his office for the practice of medicine, the format of said announcement to be such as may be approved from time to time by the Medical and Chirurgical Faculty.

(d) A physician may exhibit signs on or in the premises of the building wherein he practices, the form, content and general manner of said signs shall be as established from time to time by regulations of the Board. There shall be no more than three such signs on or in each premises or building.

RECOGNITION OF FRANK K. MORRIS, M.D., DECEASED

J. Emmett Queen, M.D., noted the sudden death of Frank K. Morris, M.D., Secretary-Treasurer of the Board of Medical Examiners, and moved "That a moment's silence be observed in his memory and that the family of the late Dr. Morris be advised of this action." This motion was adopted unanimously and the House rose in observing a moment's silence in memory of the late Dr. Morris.

HOUSE ADJOURNED

There being no further business, the House adjourned at 5:20 p.m., *sine die.*

WILLIAM A. PILLSBURY MD, Secretary

Report of the Ad Hoc Committee on Changes in the Medical Practice Act.

Mr. President and Members of the House of Delegates:

PROPOSED COMMISSION ON MEDICAL DISCIPLINE

Basically, this revised proposal incorporates the following changes in the original proposal. The Board of Medical Examiners is now in complete agreement with this revised proposal.

1. Change in the composition of the Commission on Medical Discipline so that it now provides for the Chairman of the Council of the Faculty, as well as three members of the Board of Medical Examiners

selected by that Board.

2. Removal of all references in the current Medical Practice Act to revocation, suspension or placing on probation of physicians so that this function is performed entirely by the proposed Commission on Medical Discipline.
3. Removal of reference to use of outside legal counsel, so that all advice on legal matters will be obtained through the Attorney-General's office, as is customary with all state agencies.

Section 18

The Commission on Medical Discipline of Maryland, hereby established and hereafter referred to in this Chapter as the Commission, shall consist of the following persons:

The President of the Medical and Chirurgical Faculty of the State of Maryland

The Immediate Past-President of the Medical and Chirurgical Faculty of the State of Maryland

The President-elect of the Medical and Chirurgical Faculty of the State of Maryland

Two Practicing Physicians appointed by the Governor of the State of Maryland from a list submitted by the Medical and Chirurgical Faculty of the State of Maryland

Three Members of the Board of Medical Examiners to be selected by said Board of Medical Examiners

The Chairman of the Council of the Medical and Chirurgical Faculty of the State of Maryland

Seven of the nine members of the Commission shall constitute a quorum for the transaction of all business.

The Commission may establish and maintain an office within this State and shall make, adopt and promulgate rules and regulations for its own government and for the proper supervision and control of the professional conduct of all persons under its jurisdiction, not inconsistent with the laws of this State or of the United States.

There shall always be nine members and no person shall serve in a dual capacity. In the event of such occurrence, the Governor may designate a practicing physician from a list submitted by the Medical and Chirurgical Faculty.

(a) *Terms of Office:* The terms of office for appointees shall be for three years or until his successor is duly elected, appointed or qualified. Terms of office shall be from the 1st of July each year, except when the initial appointments are made; such appointments will be for staggered terms so as to provide for continuity on the Commission.

(b) *Reports:* The Commission shall make annual reports to the Governor, the Board of Medical Examiners and to the Medical and Chirurgical Faculty of the State of Maryland.

(c) *Removal of members:* Any member of the Commission may be removed by the Governor for neglect of duty, misconduct or malfeasance or misfeasance in office.

(d) *Compensation:* Members of the Commission shall receive no salary but may be reimbursed for actual expenses incurred in connection with their official duties with the Commission.

(e) *Duties and Obligations:* The Commission shall refer any cases coming to its attention to the appropriate Committee of the Medical and Chirurgical Faculty of the State of Maryland for investigation and report. The report shall contain such recommendations as the investigation reveals might be necessary for adequate disciplinary procedures. Such recommendations will then be considered by the Commission which will take whatever action it deems appropriate.

The Medical and Chirurgical Faculty of the State of Maryland may initiate action by virtue of information coming to its attention from its own members or through any other source, such cases being handled in the same manner as though they had been referred to it by the Commission.

(f) *Power and Duties:* The Commission shall have the power to revoke or suspend the license of or place on probation any licensed physician in the State of Maryland, for any of the causes listed below as unprofessional conduct, but such action shall not be limited to these causes:

1. Fraudulent or deceptive procuring or use of a license;
2. Solicitation or advertising contrary to Section 20;
3. Insanity or admission and confinement in a mental institution or mental hospital;
4. The performance of one or more criminal abortions;
5. Conviction of any crime involving moral turpitude;
6. Failure or refusal of a physician, without adequate cause, to render, or to arrange to have another physician render, necessary medical attention to any patient under his immediate care.
7. Addiction to narcotics, habitual drunkenness or rendering professional services to a patient if the physician is intoxicated or under the influence of narcotic drugs.
8. Having been found by a court of competent jurisdiction (within or without the State) to have exercised in the Practice of Medicine undue influence on a patient for financial gain.
9. Promotion by a physician of the sale of drugs, devices, appliances or goods provided for a patient in such a manner as to exploit the patient for financial gain of the physician.
10. Immoral conduct of a physician in his practice as a physician.
11. Willfully making and filing false reports or records, in his practice as a physician.
12. Willful omission to file or record, or willfully impeding or obstructing a filing or recording, or inducing another person to omit to file or record medical reports required by law.
13. Failure to furnish details of a patient's medical record to succeeding physicians or hospital upon proper request.
14. Solicitation of professional patronage by agents or persons, or profiting from the acts of those representing themselves to be agents of the licensed physician.
15. Division of fees, or agreeing to split or divide the fees received for professional services with any person for bringing to or referring a patient.
16. Accepting rebates or kickbacks, for referral of patients.
17. Advertising professional superiority or the performance of professional services in a superior manner.
18. Willful misrepresentation in treatments.
19. Practicing medicine with an unlicensed physician except in an accredited preceptorship or residency training program; or aiding, abetting such unlicensed person in the practice of medicine.
20. Gross and willful and continued overcharging for professional services; including filing of false statements for collection of fees for which services

are not rendered.

21. Offering, undertaking or agreeing to cure or treat disease by a secret method, procedure, treatment or medicine.
22. Revocation of license by any other state or territory for any cause whatsoever.
23. Professional or Mental Incompetency.

(g) *Immunity from Suit:* All persons acting as members of authorized committees of the Medical and Chirurgical Faculty of the State of Maryland or as the Commission shall be immune from suit in any action, at law or equity, based upon any disciplinary proceedings or other official acts in the furtherance hereof and performed in good faith.

(h) *Subpoena:* The Commission shall have the power to issue subpoenas and administer oaths in connection with any investigation, hearing or proceeding.

(i) *Hearing and attorney rights*: Any physician who shall have a case referred to the Commission on medical discipline shall have the opportunity to appear in person before the Commission at a hearing duly convened, at which time he shall have the right to be represented by counsel and all proceedings of the Commission shall be subject to the provisions of the laws of Maryland relating to administrative bodies.

(j) *Certificate of revocation or suspension—Reprimand.* If a majority of a quorum of the members of the Commission vote in favor of finding the accused guilty of unprofessional conduct as specified in the charges, the Commission shall prepare written finding of fact and may thereafter prepare and file in the office of the Board of Medical Examiners a certificate or order of revocation, suspension or reprimand in which case thereof shall be served upon the accused.

(k) *Dismissal of charges—Exoneration.* If the license holder is found not guilty, or if less than a majority of the members vote for a finding of guilty, the Commission shall forthwith order a dismissal of the charges and the exoneration of the accused.

(l) *Revocation or suspension of license—Stay pending review.* The filing by the Commission in the office of the Board of Medical Examiners of a certificate or order of revocation or suspension, after due notice, hearing and findings in accordance with the procedure specified in this chapter, certifying that any holder of a license has been found guilty of unprofessional conduct by the Commission shall constitute a revocation or suspension of the license to practice medicine and surgery in this state in accordance with the terms and conditions imposed by the Commission and embodied in the certificate or order of revocation or suspension. If the licensee seeks judicial review of the Commission's decision pursuant to the provisions of this chapter, such revocation or the period of such suspension shall be stayed and shall not be effective or commence to run until final judgment has been entered in any proceeding instituted under the provisions of this chapter and the licensee's judicial remedies exhausted hereunder.

(m) *Contents of certificate—Recording.* The certificate or order of revocation or suspension shall contain a brief and concise statement of the ground or grounds upon which the certificate or order is based and the specific terms and conditions of such revocation or suspension, and shall be retained as a permanent record by the Board of Medical Examiners as well as by the Commission.

(n) *Issuance of license after revocation or suspension.* The Board of Medical Examiners shall not issue any license or any renewal thereof to any person whose license has been revoked or suspended by the Commission except in conformity with the terms and conditions of the certificate or the order of revocation or suspension, or in conformity with any order of reinstatement issued by the Commission or in accordance with the final judgment in any proceeding for review.

(o) *Appeal from decision by Commission.* Any person whose license has been revoked or suspended by the Commission, or if said person is placed on probation, he shall have the right to a judicial review of the Commission's decision. He may enter an appeal to the Circuit Court of Baltimore City and serve notice of said appeal on the Commission within 30 days after the filing of the Certificate or of the revocation, suspension or probation. All parties, including the Commission, shall have the right of further appeal to the Court of Appeals of Maryland.

JOHN M. DENNIS, MD, *Chairman*
LEWIS P. GUNDRY, MD
KARL F. MECH, MD
WILLIAM A. PILLSBURY, MD

SECTION 20—MEDICAL PRACTICE ACT

Reference is made to this Section in the *Proposed Commission on Medical Discipline, Section 18, under "f" (2)**

Section 20.

No physician shall advertise except in the following manner:

(a) A physician may use a personal professional card not larger than three and one-half inches by two inches, upon which may be printed his name, title, address, specialty, telephone number and office hours and nothing else.

(b) A physician may send removal notices to any of his bona fide patients or to any other physician, notifying them that he is removing his offices from one address to another. Such notices, upon which may be printed his name, title, specialty, telephone number, office hours, residence and business addresses, information necessary to indicate the removal of offices and nothing else, shall not be larger than five inches by seven inches.

(c) A physician may send to any other physician of his choosing an announcement that he has opened an office or changed the professional composition of his office for the practice of medicine, the format of said announcement to be such as may be approved from time to time by the Medical and Chirurgical Faculty

(d) A physician may exhibit signs on or in the premises of the building wherein he practices, the form, content and general manner of said signs shall be as established from time to time by regulations of the Board. There shall be no more than three such signs on or in each premises or building.

★★★★★★★★★★★★★★★★★★

BALTIMORE CITY HEALTH DEPARTMENT

ROBERT E. FARBER, M.D., M.P.H.
COMMISSIONER

American Building, Baltimore and South Streets
Baltimore, Maryland 21202

752-2000: Extension 307

Learn To Do Your Part In The Prevention Of Disease

Birth and Fetal Death Certificate Forms Revised

Beginning January 1, 1968 the Baltimore City Health Department will put into use revised birth and fetal death certificate forms. There is no significant change in the "Certificate of Death" form. Hospital medical directors and medical records personnel have been advised of these changes. Reproductions of the "Certificate of *Live Birth*" and the "Certificate of *Fetal Death*" are presented herewith for reference.

CHANGES MADE IN CERTIFICATE OF LIVE BIRTH FORM

1. Item #6D asks whether the "Usual Residence of Mother" was or was not within city limits. (Enter "Yes" if the mother's residence is inside the boundaries of an incorporated city, town or location mentioned in #6C; otherwise, enter "No".)
2. Item #14 is for "Termination of Last Pregnancy At Any Time After Conception" by month and year. This means any pregnancy regardless of whether it resulted in an abortion, miscarriage, fetal death, or live birth.
3. Item #15 asks whether Item #14 was or was not a live birth.
4. Item #18B is concerned with the "Month of Pregnancy Prenatal Care Began." (Enter the number of months that the mother was pregnant when she first received care from a physician or attended a prenatal clinic for this pregnancy.)
5. Item #22 "Method of Delivery" replaces the former item for "Operative Procedures" (in the left margin).
6. Item #23 "Source(s) of Prenatal Care" replaces the former item in the left margin as to whether the mother was "a private physician's or a hospital service patient."
7. Item #25 calls for the "Lowest Apgar Score" and the number of minutes after birth that it was recorded. As a guide to prognosis and the need for particularly close observation or care in the delivery room and nursery, Dr. Virginia Apgar has devised a method of scoring which is of practical value. Sixty seconds after the complete birth of the infant (disregarding the cord and placenta), the 5 objective signs listed in the table below are evaluated and each given a score of 0, 1, or 2. A total score of 10 indicates an infant in the best possible condition.
8. Item #26 asks if the mother is "Certified for Medical Assistance Program"; if so, the "Program Case No." is to be listed.
9. Item #27 replaces the former items for "Occupation and Industry of the Father." The new item calls for the "Highest Grade of School Completed by both the Father and the Mother." You should enter the highest grade completed in "regular" schooling in the spaces for "Elementary School," "Junior High School," "Senior High School" or "College." (Do NOT enter any other kind of schooling or training. While beauty and barber schools, business or trade schools and the like are important, they are not considered "regular" schools for the purpose of this item.)

CHANGES MADE IN CERTIFICATE OF FETAL DEATH FORM

1. Item #6D—same as on the Certificate of Live Birth form (see above).
2. Item #17, "Direct and Antecedent Causes":
   (a) Line (A) calls for the "Immediate Cause of Fetal Death."
   (b) The expression "Due to" has been changed to "Due To or As A Consequence Of."
3. Item #20B is a continuation of the item "Was Autopsy Performed?"—The additional information asks "If Yes, Were Findings Considered in Certifying Causes of Death?"

EVALUATION OF THE NEWBORN INFANT

Sign	0	1.	2.
Heart rate	Absent	Below 100	Over 100
Respiratory effort	Absent	Slow, irregular	Good, crying
Muscle tone	Limp	Some flexion of extremities	Active motion
Response to catheter in nostril (tested after oropharynx is clear)	No response	Grimace	Cough or sneeze
Color	Blue, pale	Body pink, extremities blue	Completely pink

CONFIDENTIAL MEDICAL REPORT

This Part Must Be Filled Out. It Will Not Be Reproduced On Copies.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF FETAL DEATH

REG. NO. _____

1. NAME OF FETUS (IF GIVEN)

2A. DATE OF DELIVERY (MONTH) (DAY) (YEAR)

2B. HOUR M.

3. SEX OF FETUS: MALE ☐ FEMALE ☐ UNDETERMINED ☐

4A. THIS DELIVERY WAS: SINGLE ☐ TWIN ☐ TRIPLET ☐

4B. IF TWIN OR TRIPLET, THIS FETUS WAS DELIVERED: 1ST ☐ 2ND ☐ 3RD ☐

5. PLACE OF DELIVERY IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

6. USUAL RESIDENCE OF MOTHER (WHERE DOES MOTHER LIVE?)
A. STATE B. COUNTY
C. CITY OR TOWN
D. INSIDE CITY LIMITS? YES ☐ NO ☐
E. STREET AND NUMBER

7. FATHER'S NAME A. (FIRST) B. (MIDDLE) C. (LAST)

8. RACE

9. AGE (AT TIME OF DELIVERY) _____ YEARS

10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

11. MOTHER'S MAIDEN NAME A. (FIRST) B. (MIDDLE) C. (LAST)

12. RACE

13. AGE (AT TIME OF DELIVERY) _____ YEARS

14. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

15. CHILDREN PREVIOUSLY BORN TO THIS MOTHER (DO NOT INCLUDE THIS CHILD)

A. HOW MANY ARE NOW LIVING?

B. HOW MANY BORN ALIVE NOW DEAD?

C. HOW MANY WERE STILLBORN (BORN DEAD AFTER 20 WEEKS PREGNANCY)?

16. TERMINATION OF LAST PREGNANCY AT ANY TIME AFTER CONCEPTION.
MONTH YEAR

17. WAS THIS A LIVE BIRTH? YES ☐ NO ☐

18. CAUSE OF FETAL DEATH

I. DIRECT AND ANTECEDENT CAUSES (ENTER ONLY ONE CAUSE PER LINE)

DIRECT CAUSE
STATE FETAL OR MATERNAL CONDITION DIRECTLY CAUSING FETAL DEATH (DO NOT USE SUCH TERMS AS STILLBIRTH OR PREMATURITY.)
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES
STATE FETAL AND/OR MATERNAL CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CAUSE LAST.
(B) _____
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____

II. OTHER SIGNIFICANT CONDITIONS OF FETUS OR MOTHER WHICH MAY HAVE CONTRIBUTED TO FETAL DEATH, BUT, IN SO FAR AS IS KNOWN, WERE NOT RELATED TO DIRECT CAUSE OF FETAL DEATH.

19. WHEN DID FETUS DIE: BEFORE LABOR ☐ DURING LABOR OR DELIVERY ☐ UNKNOWN ☐

20A. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

I CERTIFY THAT THIS DELIVERY OCCURRED ON THE DATE STATED ABOVE AND THE FETUS WAS BORN DEAD.

21A. ATTENDANT'S SIGNATURE M.D. ☐ D.O. ☐ MIDWIFE ☐ OTHER (SPECIFY)

21B. DATE SIGNED

21C. ATTENDANT'S NAME (TYPE OR PRINT)

22. ADDRESS (STREET, CITY, TOWN, OR STATE)

23A. FIRST DAY OF LAST NORMAL MENSES 19

23B. MONTH OF PREGNANCY PRENATAL CARE BEGAN (1ST, 2ND, 3RD, ETC. OR NONE)

23C. WEIGHT OF FETUS GRAMS OR LBS. OZS.

24A. BURIAL ☐ CREMATION ☐ REMOVAL ☐ RELEASED TO HOSPITAL ☐

24B. DATE

24C. NAME OF CEMETERY, CREMATORY OR HOSPITAL

24D. LOCATION (CITY, TOWN, COUNTY) (STATE)

25. DATE REC'D BY HEALTH DEPT.

26. NAME OF REGISTRAR

27. FUNERAL DIRECTOR ADDRESS

A CERTIFICATE OF FETAL DEATH MUST BE EXECUTED WITHIN 24 HOURS FOR EVERY FETUS DEAD AT BIRTH IF THE PERIOD OF GESTATION IS 20 OR MORE WEEKS, OR IF THE PERIOD OF GESTATION IS UNKNOWN AND THE FETUS WEIGHS 400 OR MORE GRAMS.

VS 140—REV. 1/1/68

28. METHOD OF DELIVERY
1. ☐ Spontaneous
2. ☐ Forceps, Low
3. ☐ Forceps, Other
4. ☐ Cesarean Section
5. ☐ Breech Delivery
6. ☐ Other (Specify)

29. SOURCE(S) OF PRENATAL CARE (CHECK ALL WHICH APPLY)
1. ☐ None
2. ☐ Private M.D.
3. ☐ Hospital Clinic
4. ☐ Health Dept. Clinic
5. ☐ Other (Specify)

30. CONGENITAL MALFORMATIONS
1. ☐ None Apparent
2. ☐ Yes (Specify)

31. CERTIFIED FOR MEDICAL ASSISTANCE PROGRAM
NO ☐ YES ☐
Program Case No. _____

32. HIGHEST GRADE OF SCHOOL COMPLETED BY:

	A. FATHER	B. MOTHER
Elementary 1. 1-6 yrs.	☐	☐
Jr. High School 2. 7-9 yrs.	☐	☐
Sr. High School 3. 10-11 yrs.	☐	☐
4. 12 yrs.	☐	☐
College 5. 1-3 yrs.	☐	☐
6. 4 or + yrs.	☐	☐

CONFIDENTIAL MEDICAL REPORT

22. METHOD OF DELIVERY
1. ☐ Spontaneous
2. ☐ Forceps, Low
3. ☐ Forceps, Other
4. ☐ Cesorean Section
5. ☐ Breech Delivery
6. ☐ Other (Specify)

23. SOURCE(S) OF PRENATAL CARE CHECK ALL WHICH APPLY)
1. ☐ None
2. ☐ Private M.D.
3. ☐ Hospital Clinic
4. ☐ Health Dept. Clinic
5. ☐ Other (Specify)

24. CONGENITAL MALFORMATIONS
1. ☐ None Apparent
2. ☐ Yes (Specify)

25. LOWEST APGAR SCORE
_____ At _____ Min.

26. CERTIFIED FOR MEDICAL ASSISTANCE PROGRAM
No ☐ Yes ☐
Program Case No. _____

27. HIGHEST GRADE OF SCHOOL COMPLETED BY:

	A-FATHER	B-MOTHER
Elementary 1. 1-6 yrs.	☐	☐
Jr. High School 2. 7-9 yrs.	☐	☐
Sr. High School 3. 10-11 yrs.	☐	☐
4. 12 yrs.	☐	☐
College 5. 1-3 yrs.	☐	☐
6. 4 or + yrs.	☐	☐

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF LIVE BIRTH

REG. NO. 154— _____

1. CHILD'S NAME (Type or Print) a. (First) b. (Middle) c. (Last)

2. SEX

3A. THIS BIRTH SINGLE ☐ TWIN ☐ TRIPLET ☐

3B. IF TWIN OR TRIPLET (This child born) 1ST ☐ 2ND ☐ 3RD ☐

4A. DATE OF BIRTH

4B. HOUR M

5. PLACE OF BIRTH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

6. USUAL RESIDENCE OF MOTHER (Where does mother live)
A. STATE B. COUNTY
C. CITY OR TOWN
D. INSIDE CITY LIMITS? YES ☐ NO ☐
E. STREET AND NUMBER

FATHER OF CHILD

7. FULL NAME a. (First) b. (Middle) c. (Last)

8. AGE (At time of this birth) YEARS

9. BIRTH-PLACE (State or foreign country)

MOTHER OF CHILD

10. FULL MAIDEN NAME a. (First) b. (Middle) c. (Last)

11. AGE (At time of this birth) YEARS

12. BIRTH-PLACE (State or foreign country)

13. CHILDREN PREVIOUSLY BORN TO THIS MOTHER (Do NOT include this child)
a. How many are now living?
b. How many born alive now dead?
c. How many were stillborn (born dead after 20 weeks pregnancy)?

14. TERMINATION OF LAST PREGNANCY AT ANY TIME AFTER CONCEPTION.
MONTH YEAR

15. WAS THIS A LIVE BIRTH? YES ☐ NO ☐

16. Date Rec'd by Health Dept. _____
Name of Registrar _____

AMENDMENTS MADE ON CERTIFICATE

A. ☐ _____ DATE Given name added by _____ on request from _____
B. ☐ _____ DATE Amended by _____ on request from _____
C. ☐ _____ DATE Amended from documentary evidence
D. ☐ _____ DATE Amended from court order change of name

17. I certify that this child was born alive on the date and hour stated above.
Attendant's Signature _____ M.D. ☐ D.O. ☐ Midwife ☐
Physician (or midwife) who attended this birth
Attendant's Name _____ (Type or Print)
or _____ M.D.
Commissioner of Health and Registrar
Address _____ DATE

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18A. FIRST DAY OF LAST NORMAL MENSES

18B MONTH OF PREGNANCY PRENATAL CARE BEGAN (1st, 2nd, 3rd, etc. or none)

18C WEIGHT OF CHILD AT BIRTH GRAMS OR LBS. OZS

19. RACE OF FATHER WHITE ☐ NEGRO ☐ OTHER (Specify) _____

20. RACE OF MOTHER WHITE ☐ NEGRO ☐ OTHER (Specify) _____

21. MOTHER'S NAME AND ADDRESS FOR MAILING REGISTRATION NOTIFICATION:

DO NOT WRITE IN THIS SPACE—RESERVED FOR CODING

VS 100-REV. 1/1/68

If there are any questions concerning the above revisions call Mr. Sidney M. Norton, Director, Bureau of Vital Records, Municipal Building, Holliday and Lexington Streets, telephone 752-2000, extension 827.

Robert E. Farber, MD
Commissioner of Health

Pediatrics
SPONSORED BY THE MARYLAND CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS
WILSON L. GRUBB, MD, Chairman
RAY HEPNER, MD, Editor

Head Growth During Infancy

ROBERT S. MOSSER, MD
University of Maryland
School of Medicine

The growth of the head during the first two years of life reflects the growth of the intracranial contents and provides the physician with a valuable clinical sign which may be of value in the early diagnosis and treatment of hydrocephalus. Normal head growth usually means normal brain growth, and from a less optimistic point of view, reduction of head growth rate may be of prognostic value as an early indication of mental deficiency. Parents are usually quite aware of deficiencies in growth of their infants. Weight is particularly noted and becomes a part of the birth announcement to the point of being a national news item along with sex and given name when famous parents are involved. Body length and height later receive consideration. Head size and growth are usually little noted, and it remains the responsibility of the infant's physician to repeatedly measure and record head circumference throughout the first year or two of life. With the help of readily available graphs of normal distribution, the infant can be compared to a large normal population as well as to himself with respect to this important objective measurement.

Infant head growth is of importance as a measure of brain growth in the normal situation, but at times represents the combination of brain growth and the presence or accumulation of an additional space-occupier such as abnormal fluids, including blood or, less commonly, tumor. Head circumference measurements are reliably reproduced by several observers when taken at the largest possible circumference using an accurate pliable plastic or paper tape. In the absence of skull deformity of considerable degree, circumference becomes a clinically reliable index of intracranial mass.* The opposite is true for an elongated skull with transverse flattening so frequently seen in low birth weight infants. A more circular circumference where the head is broad with shortened antero-posterior diameter will, of course, show relatively low circumference with respect to intracranial mass. Skull thickness is so nearly uniform that it does not ordinarily come into consideration.

There are probably only two exceptions to the rule that unusually small heads are regularly accompanied by mental deficiency of some degree. Small head size may be a family trait. There are certainly families where small heads or large heads are the rule, and usually it is possible for parents to trace the trait through several generations on one or both sides of the family. The second exception is the small head which results from premature synostosis of the cranial sutures. These children are not necessarily retarded in any sphere at the time that the diagnosis is made, and they usually receive surgical correction of the skull abnormality so that untreated follow-up cases are infrequently available.

Both primary and secondary microcephaly are regularly attended by mental deficiency. Primary microcephaly is accompanied by pathological

*In oxycephaly, where the skull is unusually high, circumference may be relatively small with respect to intracranial mass.

changes suggesting defective in-utero organogenesis. The adult head circumference in these children is usually less than 43 centimeters. Secondary microcephaly follows traumatic lesions, encephalitis, meningitis, metabolic encephalopathies, cerebral anoxia, and other cerebral disturbances. The head is usually well below the 3rd percentile for age and sex. Frequently the primary disease or insult to the nervous system cannot be determined.

It is important at this point to recall that although the brain is decelerating in growth rate at the time of birth, it (along with many other organs) is destined to triple its birth weight during the first year of life. It differs from other large organs, however, in that the potential for growth is greatly reduced during the second year of life at which time 80% of adult mass is attained. Growth and differentiation lost during the important first year cannot be reclaimed.

Average adult brain weights are accepted as being about 1360 grams for males and 1230 grams for females. It is generally accepted that weight variations in the broad normal range show no correlation with mental abilities, but that adult brain mass of less than 960 grams (the brain size of a one-year old) is incompatible with normal intellectual function in the male. 800 grams is the equivalent female weight. According to Lassek (*The Human Brain*, Chas. C. Thomas, 1957) weights at this level are found among idiots. It would be injudicious for a physician to tell the parents of a six-month-old with a head circumference of a two-month-old not to worry because "He'll outgrow it."

Head growth during early life is frequently independent of somatic growth. Every physician who deals with infants can recall having seen severe growth or nutritional failure patients whose heads appeared to be abnormally large. Measurements of such heads almost always show that they are within the normal size range for age. There is no good reason to suspect that the intellectual endowment of these "failure to thrive" infants will not remain intact if their primary condition causing growth failure is treated.

Infants whose head growth is far too rapid in early life present more of a challenge in that they must all be suspected of having a surgically treatable condition requiring early diagnosis. Familial macrocephaly with normal intellect presents no great problem except as a point of differential diagnosis prior to the time when intellect can be judged with accuracy. Pathologic macrocephaly without hydrocephalus which is accompanied by intellectual deficit is not treatable, but fortunately is a rare condition. After eliminating these two causes for early rapid head growth one is left with hydrocephalus not obviously present at birth but developing during early life due to a congenital, inflammatory or neoplastic lesion. Treatment for communicating hydrocephalus may be in the form of repeated lumbar punctures, by one of a number of shunting procedures or by attempted direct attack on an anatomic structure causing obstruction to the cerebrospinal fluid pathway. These procedures are all fraught with danger and complications, and they are frequently not successful, but they continue to be our only form of treatment and, with rare exceptions, should be used in all cases. Attention to head growth that makes early diagnosis possible frequently enhances the chances of success of such procedures. A large part of the medical profession's lack of enthusiasm for the treatment of hydrocephalus is caused by therapy undertaken too late to be successful. Active hydrocephalus destroys brain tissue and late therapy, no matter how successful, does not restore tissue.

Hydranencephaly, porencephalic cysts, compensatory hydrocephalus, and other less common fluid-containing intracranial lesions are most often of prenatal origin and not usually associated with head enlargement beyond normal limits, although exceptions do occur. Chronic subdural hematoma from injury at the time of birth or during very early life may produce abnormal head growth, particularly in the early months. This is a treatable lesion in the very early stages and one cannot rely upon changes in head growth as a criterion for undertaking the diagnosis.

An attempt has been made to outline the major causes of abnormally slow or rapid head enlargement in infancy. This easily obtained objective measurement is of value prognostically in preparing a family to help their mentally retarded child through life, and therapeutically when it allows the physician to reclaim some potential mental retardates by promoting more frequent and earlier treatment of active hydrocephalus.

the HEART PAGE
A Service of The Heart Association of Maryland
Chris Papadopoulos, MD—Editor

PULMONARY EMBOLISM

A. HASSAN KHAZEI, MD
Division of Thoracic and Cardiovascular Surgery
University of Maryland Hospital
and
South Baltimore General Hospital

Pulmonary emboli have been found at autopsy in approximately 10% of general hospital patients and in a higher percentage of institutional patients with cardiac or prostatic disease. There is a disparity between the small number of ante mortem diagnoses and the incidence of pulmonary embolism found at necropsy. This gap is due to the paucity of symptoms, acuteness and severity in cardiopulmonary hemodynamics causing rapid death, and lack of quick and precise diagnostic methods. The success in dealing with pulmonary embolism depends greatly on the physician's awareness and suspicion of the common occurrence of this complication.

The principle source of emboli lies in the deep veins of the thighs, calves, pelvis and right heart. In at least 20% of patients, no source will be discovered at autopsy, and in a similar number, multiple sources will be found. Most patients with thromboembolic phenomenon do not have evidence of antecedent venous thrombosis, and in over 50% of patients, the pulmonary embolism will be the first sign.[1] A patient having one pulmonary embolus has a 30% chance of having a second and an 18% chance of having a subsequent fatal embolus.

The symptoms of pulmonary embolism depend primarily on the size of the embolus or emboli and the previous functional state of the heart and lungs. The clinical picture often reflects the effects of reduced cardiac output with weakness, sweating, syncope, apprehension, hyperpnea, restlessness, and peripheral vasoconstriction. Retrosternal chest pain may be prominent in massive embolism. The symptomatology may be totally lacking in spite of massive pulmonary embolism until a short time before death. Frequently, tachypnea is present. Unexplained tachypnea should raise the suspicion of pulmonary embolism. Physical signs include pulsation in the second left interspace, a pseudo-pericardial friction rub, a systolic and, at times, a diastolic murmur and thrill at the second left interspace, an interscapular bruit, increased cardiac dullness on the right, and gallop rhythm. Unfortunately, these signs are neither common nor characteristic. However, an accentuated P2, distended neck veins and enlarged liver when present are important diagnostic leads. These signs are only significant in the absence of preexisting pulmonary hypertension. It should be remembered that an accurate diagnosis between massive pulmonary embolism and coronary occlusion is not always possible and that the possibility of this complication should be thought of each time that one is confronted with a suspected

diagnosis of myocardial infarction.

The characteristic electrocardiographic findings are usually lacking but consist of right heart strain, that is, a deep **S** wave in lead 1, a deep **Q** wave in lead 3, depressed **ST** segment in lead 2, and inverted **T** waves in leads 2 and 3. Changes may be reflected in the right precordial leads. Israel and Goldstein reported significant changes in the electrocardiograms of 70% of their patients who had at least two tracings made after pulmonary embolism.[2] X-ray findings are varied and may be of considerable diagnostic assistance. Evidence of pulmonary infarction on a plain film may be suggestive. However, infarction of the lung may not occur because of the dual circulation of the lungs. In general, pulmonary embolism lodging even in major pulmonary arteries produces infarction only when there is associated infection or when there is passive congestion in the lung. Therefore, the absence of infiltration on a plain film is not indicative of absence of embolism. Arendt and Rosenberg found that 50% of all patients clinically suspected of having pulmonary embolism develop an infarction that can be demonstrated by a plain chest X-ray.[3] The so called "anemic lung," hypovascularity of a portion or the entire one lung, is of diagnostic value but occurs rarely. Pulmonary angiography remains the best diagnostic method available today. However, a negative angiogram does not necessarily rule out the possibility of emboli in the pulmonary vasculature. Similarly, this technique does not indicate precisely the magnitude or the degree of obstruction. Lung scanning is similarly of considerable value in the diagnosis, although a number of false-positive findings in patients free of pulmonary embolism have been reported. Recently, ultrasound has been used in the diagnosis of this complication and appears to be promising. However, more experience is necessary before its true value can be determined.[4]

Intravenous or deep intramuscular heparinization is the treatment of choice. Inferior vena caval disruption is employed when the use of heparin is contraindicated, e g., hemorrhagic diathesis, significant hypertension, and acute duodenal ulcer, or when there is repeated pulmonary embolus in spite of adequate heparinization. The application of a caval clip is preferred to caval ligation since the incidence of postoperative edema and pain in the lower extremities is significantly reduced.

Pulmonary embolectomy is reserved for instances where recovery seems otherwise unlikely. The difficulty, however, lies in the selection of these patients. Hypotension is usually indicative of a low cardiac output as a result of significant obstruction to the pulmonary blood flow and is a common indication for surgical intervention.[5]

Measurement of right ventricular pressure *RVP* during angiography is indicated. An increase in *RVP* (systolic or end diastolic) is an indication of significant obstruction to the flow of blood through the lung and is usually associated with poor prognosis unless the obstruction is relieved. Finally, in certain circumstances where the presence of a massive pulmonary embolism can be established without doubt, one may select to proceed with embolectomy in spite of a relatively normal blood pressure and *RVP*.[5]

Recently, Urokinase has been used in a small number of patients with encouraging results, but more experience is necessary before conclusions are made.[6]

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Against these three major pathogens...



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V-Cillin K has been shown to be effective in the treatment of streptococcus and pneumococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy in patients with a history of rheumatic fever or congenital heart disease.

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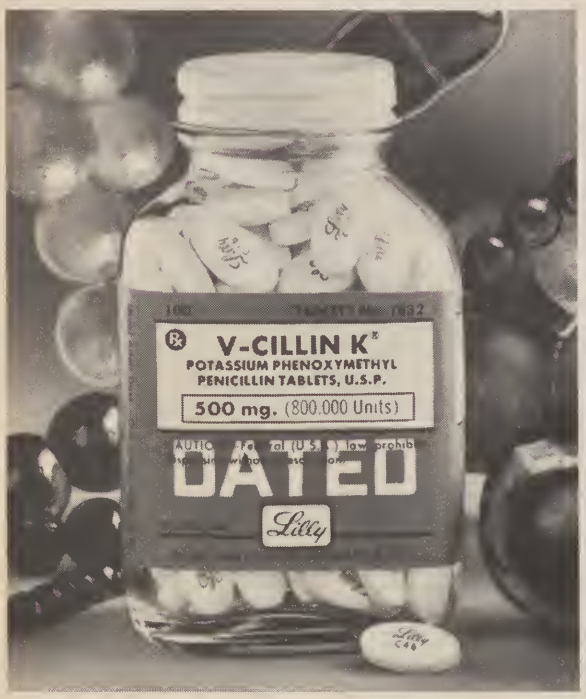
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(See next page for prescribing information.)

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Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [042567]

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

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Consider starting your hypertensives on this basic thiazide

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Enduron is a true 24-hour single-dose thiazide. Its sodium excretion is not squeezed into an abrupt peak during the first several hours. It is well-sustained in a plateau-like effect—with little reduction for the first 12 hours, and decline thereafter only gradual.

Potassium loss, by contrast, is low. It reaches an early minor peak, then subsides rapidly. Moreover, since dosage is but once a day, there is but one daily peak of potassium loss. As with all thiazides, however, dietary potassium supplementation should also be considered, especially in long or intensive therapy.

Use Enduron as an ideal starting therapy in mild hypertension. Use it too, as a basic therapeutic building block with which other agents can be joined, for managing your more resistant hypertensives.

Once a day, every day

ENDURON®
METHYCLOTHIAZIDE



DAILY DOSAGE RANGE	Minimum	Usual	Intermediate	Maximum
	2.5 mg. tablet	5 mg. tablet	7.5 mg.	10 mg.

See Brief Summary on final page of advertisement.

To build added response, shift to Enduronyl

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The deserpidine component adds enhanced antihypertensive activity

The rauwolfia component of Enduronyl is deserpidine (Harmonyl®), a purified crystalline alkaloid supplied only by Abbott. It augments Enduron with its own antihypertensive and tranquilizing action.

Thus the combined clinical effect of these two therapeutic building blocks in Enduronyl is greater than can ordinarily be achieved with either alone.

To add flexibility, Enduronyl comes in two strengths: regular and Forte. Both provide 5 mg. of Enduron. The variation is where most helpful: in the deserpidine. The tablets are scored, and give a surprisingly wide and economical choice of once-a-day doses (see below).

Choose Enduronyl for your patients in the broad range of mild to moderate hypertension. Patient acceptance is excellent!



Once a day, every day

ENDURONYL®

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.25 MG.

ENDURONYL FORTE

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.5 MG.

	Minimum	Usual	Intermediate	Maximum
DAILY DOSAGE RANGE	2.5 mg. methyclothiazide 0.125 mg. deserpidine	5 mg. methyclothiazide 0.25 mg. deserpidine	7.5 mg. methyclothiazide 0.375 mg. deserpidine	10 mg. methyclothiazide 0.5 mg. deserpidine
DAILY DOSAGE RANGE	2.5 mg. methyclothiazide 0.25 mg. deserpidine	5 mg. methyclothiazide 0.5 mg. deserpidine	7.5 mg. methyclothiazide 0.75 mg. deserpidine	10 mg. methyclothiazide 1 mg. deserpidine

See Brief Summary on final page of advertisement.

707075-R

Eutonyl affords a different kind of basic therapy for moderate to severe cases

Effect tied to reduced peripheral vascular resistance; no central depressant action

Eutonyl is a unique nonhydrazine agent. It is reported to act by reducing peripheral vascular resistance.[1,2]

In clinical trials, significant reductions in mean blood pressure were seen in 84% of patients studied—all were moderate to severe cases. Eutonyl lowers diastolic in proportion to systolic, and in about half of the cases studied, reductions in the sitting and recumbent positions were nearly as great as in the standing position.

Most important: There is no central depressant action. In fact, some patients reported an *increased* sense of well being.

Here, then, is a highly effective *basic treatment* for moderate to severe cases—and one that will not hamper your patient with lethargy or drowsiness while on treatment.

Once a day, every day

EUTONYL®
PARGYLINE HYDROCHLORIDE



DAILY DOSAGE RANGE	Minimum	Usual starting	Intermediate	Maximum
	10 mg. tablet	25 mg. tablet	50 mg. tablet or as needed	200 mg.

1. Brest, A. N., et al., Cardiac and Renal Hemodynamic Response to Pargyline, Ann. N. Y. Acad. Sci., 107-1016, 1963.
2. Winsor, T., Pargyline Hydrochloride, Hypertension, Urinary Tryptamine, and Vascular Reflexes, Geriatrics, 19:598, Aug., 1964.

See Brief Summary on final page of advertisement.

Eutron adds thiazide for enhanced therapy with milder side effects

ABBOTT

Only a 7/4 mm. span between standing and recumbent pressures in clinical trials—reduced chance of orthostatic hypotension

The combining of Eutonyl and Enduron in Eutron permits a significantly greater antihypertensive effect than with either agent used alone. This in turn may allow therapeutic success with lesser dosage—and correspondingly milder side effects.

A significant finding in clinical trials was the drug's action in lowering blood pressure to *nearly equal levels in all body positions*. Total average spread between standing and recumbent readings (after treatment) was only 7/4 mm. Hg.

Thus, in your moderate to severe cases, Eutron affords a usually smooth course of therapy, often with reduced likelihood of orthostatic effects. (The usual precautions against rising suddenly, of course, will always apply.) And, because of the thiazide component, Eutron may be used in the presence of congestive heart failure.



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EUTRON™

PARGYLINE HYDROCHLORIDE 25 MG.
WITH METHYCLOTHIAZIDE 5 MG.

DAILY DOSAGE RANGE	Minimum	Usual starting	Intermediate	Maximum
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See Brief Summary on final page of advertisement.

TM—Trademark

707075-R

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Enduron is used to control edema and mild to moderate hypertension; also used with other drugs for hypertension. Enduronyl is used in mild to moderately severe hypertension; when used with Enduronyl, more potent agents can be given at reduced dosage to minimize undesirable side effects.

Contraindications: Neither Enduron nor Enduronyl should be used in severe renal disease (except nephrosis) or shutdown; in severe hepatic disease or impending hepatic coma; in patients sensitive to thiazides. Hepatic coma has been reported as a result of hypokalemia in patients receiving thiazides.

Enduronyl is contraindicated in patients with severe mental depression and suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity reactions in patients with a history of allergy or asthma. If added potassium intake is indicated, dietary supplementation is recommended. Enteric-coated potassium tablets should be reserved for cautious use only when adequate dietary supplementation is not practical because those tablets may induce serious or fatal small bowel lesions consisting of stenosis with or without ulceration. These small bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs.

Precautions: Use thiazides with caution in severe renal dysfunction, impaired hepatic function, or progressive liver disease. In surgical patients, thiazides may reduce the response to vasopressors and increase the response to tubocurarine. Use thiazides with caution in pregnancy (bone marrow depression, thrombocytopenia, or altered carbohydrate metabolism have been reported in certain newborn infants). Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. Antihypertensive response may be enhanced following sympathectomy.

Use Enduronyl with caution in patients with a history of peptic ulcer, as rauwolfias may increase gastric secretion. Discontinue at the first sign of mental depression. Rauwolfia alkaloids may increase hypotensive effects of surgery or anesthesia, and should be discontinued two weeks prior. They also lower the convulsive threshold and shorten seizure latency. In epilepsy, dosage adjustment of anticonvulsant medication may be necessary. Alcohol, barbiturates, or narcotics may potentiate action of deserpidine.

Adverse Reactions: During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). All patients should be observed for signs of hyponatremia ("low-salt" syndrome). Reported thiazide reactions include: anorexia, nausea, vomiting, diarrhea, headache, skin rash, dizziness, paresthesia, weakness, photosensitivity, jaundice, and pancreatitis.

Reported rauwolfia reactions include: nasal stuffiness, nausea, weight gain, diarrhea, aggravation of peptic ulcer, epistaxis, skin eruption, and reduction of libido and potency. Excessive drowsiness, fatigue, weakness, and nightmares may signal early signs of mental depression.

EUTONYL® | EUTRON™

PARGYLINE HYDROCHLORIDE

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications: For treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. Not recommended for patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone. It is desirable to establish the dosage of Eutron by administering component drugs separately.

TM-Trademark.

Contraindications: Pheochromocytoma, advanced renal disease, increasing renal dysfunction, paranoid schizophrenia and hyperthyroidism. Hepatic coma has been reported as consequence of hypokalemia with thiazide therapy. Until further experience is gained not recommended for patients with malignant hypertension, children under 12, or pregnant patients.

Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. 2 week interval should separate therapy and use of these agents.

Methyclothiazide is contraindicated in patients with known sensitivity to thiazides.

Warnings: Pargyline hydrochloride is a monoamine oxidase inhibitor. Warn patients against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When indicated, alcohol, narcotics (meperidine should be avoided), antihistamines, barbiturates, chloral hydrate, and other hypnotics, sedatives, tranquilizers, or caffeine, may be used cautiously in reduced dosage. In emergency surgery ¼ to ⅓ the usual dose of narcotics, analgesics, and other premedications should be used avoiding parenteral administration where possible. Carefully adjust dose of anesthetics to response of patient. Withdraw pargyline two weeks before elective surgery.

Warn patients about the possibility of postural hypotension. Those with angina or coronary artery disease should not increase physical activity with an improvement in well being. Pargyline may lower blood sugar.

Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions consisting of stenosis with or without ulceration. These small-bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs. These products contain no added potassium salts and if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical. In patients with a history of allergy or asthma the possibility of sensitivity reactions should be considered.

Precautions: Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields and fundi. Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. In surgical patients thiazides may reduce response to vasopressors and increase response to tubocurarine.

Adverse Reactions: Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extrapyramidal symptoms have been reported in a few patients with reduced cardiac reserve.

During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). Observe all patients for signs of hyponatremia ("low salt" syndrome).

Reported thiazide reactions also include anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, and pancreatitis. Nocturia has been observed with the combination.

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Indications: Tuinal is indicated for prompt and moderately long-acting hypnosis. It is not suitable for continuous daytime sedation.

Contraindications: Barbiturates should not be administered to anyone with a history of porphyria, nor should they be given in the presence of uncontrolled pain, because excitement may result.

Warning: May be habit-forming.

Precautions: Tuinal should be used cautiously in patients with decreased liver function, since prolongation of effect may occur.

Adverse Reactions: Idiosyncrasy, such as excitement, hangover, or pain, may appear. Hypersensitivity reactions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.

Overdosage: C.N.S. depression. Symptoms—Depression of respiration and of superficial and deep reflexes, slight constriction of the pupils (in severe poisoning, dilation), decreased urine formation, lowered body temperature, coma. Treatment—Symptomatic and supportive (gastric lavage; intravenous fluids; maintenance of blood pressure, body temperature, and adequate respiration). Dialysis may speed removal of barbiturates from body fluids.



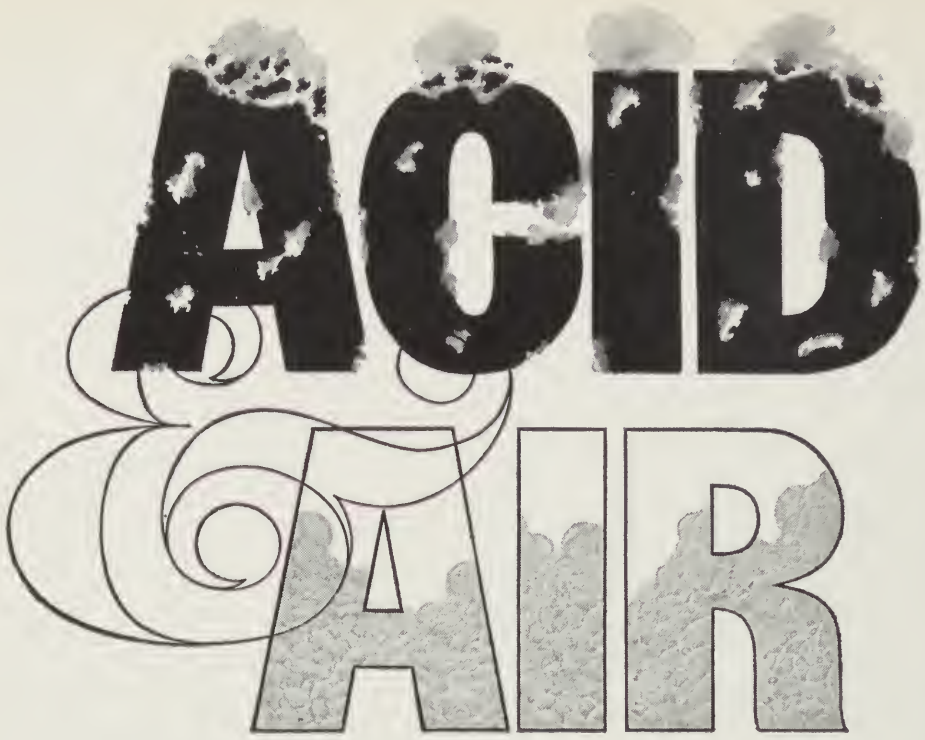
Dosage: 50-200 mg. (¾-3 grains) at bedtime.

[031767]

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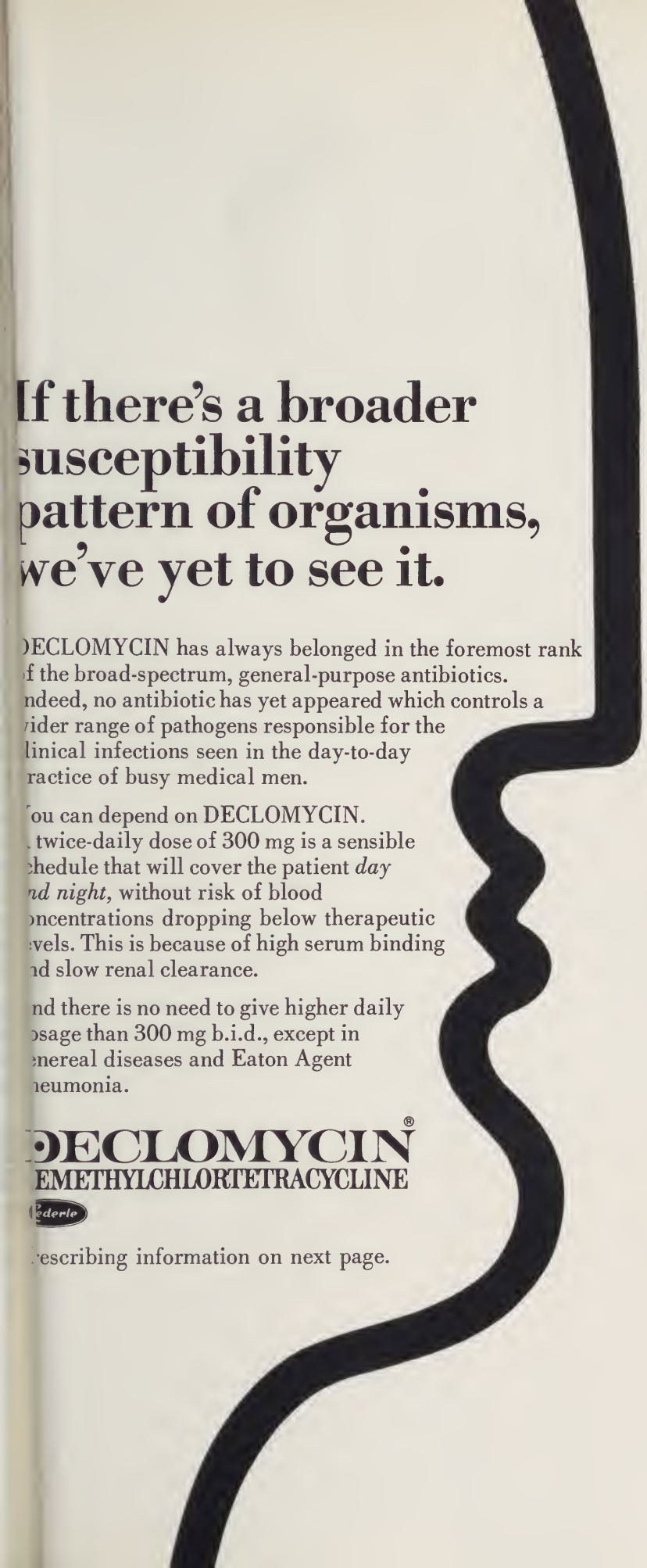
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ou can depend on DECLOMYCIN. twice-daily dose of 300 mg is a sensible chedule that will cover the patient *day nd night,* without risk of blood ncentrations dropping below therapeutic vels. This is because of high serum binding nd slow renal clearance.

Gonococcus

nd there is no need to give higher daily sage than 300 mg b.i.d., except in nereal diseases and Eaton Agent neumonia.

Shigella

DECLOMYCIN®
EMETHYLCHLORTETRACYCLINE
Lederle

Staphylococcus

escribing information on next page.

Streptococcus

Rickettsia

Treponema

Eaton Agent

Endamoeba histolytica

Hemophilus influenzae

Pneumococcus

Escherichia coli

Gonococcus

Shigella

Staphylococcus

Streptococcus

Rickettsia

Treponema

If there's a broader susceptibility pattern of organisms, we've yet to see it.

DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines when the offending organisms are tetracycline-sensitive.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions—Overgrowth of nonsusceptible organisms may occure. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes. A rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth— dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm. given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

Acute gonococcal anterior urethritis in males has been treated effectively with a single dose of 600-900 mg. of DECLOMYCIN Demethylchlortetracycline. Individuals unable to tolerate large single doses due to gastrointestinal side effects may be treated with 150 mg. every 6 hours for a minimum of 4 doses or 300 mg. every 12 hours for a minimum of 2 doses. Females should be treated with a dosage of 150 mg. every 6 hours or 300 mg. every 12 hours until a cure is affected.

Primary Atypical Pneumonia (Eaton Agent): The average adult daily dosage is 900 mg. in 3 divided doses for six days.

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"Man's best friend" in wintertime diarrheas

In winter "flu" and viral gastroenteritis, Donnagel (4 oz. size!) can bring aid and comfort to sufferers from both diarrhea and its discomforts because it contains kaolin and pectin *plus* belladonna alkaloids (as in Donnatal®). Donnagel treats the whole diarrhea problem. Available on your prescription or recommendation.

For acute, non-specific diarrheas **Donnagel® -PG** (Donnagel with paregoric equivalent). Donnagel formula plus powdered opium, USP, 24.0 mg. (equivalent to paregoric 6 ml.) (warning: may be habit forming). Alcohol, 5%.

All the antidiarrheal benefits of paregoric without the unpleasant taste. Real banana flavor makes it acceptable, even to children. See product literature before prescribing.

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Each 5 cc. contains:
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(warning: may be habit forming)
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Non-narcotic for 6-8 hour cough control
ROBITUSSIN®-DM
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Dextromethorphan hydrobromide . 15.0 mg.
Alcohol, 1.4%

New! Clears sinuses and nasal stuffiness as it relieves cough
ROBITUSSIN®-PE
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Phenylephrine hydrochloride . . . 10.0 mg.
Alcohol, 1.4%

	ROBITUSSIN	ROBITUSSIN A-C	ROBITUSSIN-DM	ROBITUSSIN-PE
EXPECTORANT	●	●	●	●
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ERYTHROCIN®-SULFAS Chewable (Erythromycin ethyl succinate-trisulfapyrimidines chewable tablet)

In clinical trials[1,2], this orange-flavored tablet was given to 55 patients, aged four months to 18 years.

Diagnoses (multiple in some cases) represented a cross section of bacterial infections commonly seen in pediatric office practice.

Therapy was given from three to 12 days, with an average of six days.

Of the 55 patients, 30 were reported cured within 72 hours, while 22 showed partial recovery within the same time, and subsequent clinical cure.

A clinical cure rate of 94.5%

ERYTHROCIN®-SULFAS Granules (Erythromycin ethyl succinate-trisulfapyrimidines granules for oral suspension)

87 patients were treated[1,2]—all children, ages four months to 15 years.

The diagnoses were multiple in some cases and were chiefly bacterial infections of the respiratory tract.

Dosage was maintained from three to 10 days; average treatment was five days. All of the ill children accepted the orange-flavored suspension favorably.

53 were clinically cured within 72 hours, while 32 showed partial relief within the same time, and subsequent clinical cure.

701358

A clinical cure rate of 97.7%

1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

ABBOTT

Brief Summary on next page

ERYTHROCIN®-SULFAS
Brief Summary

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or newborn infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. of each of sulfadiazine, sulfamerazine and sulfamethazine.

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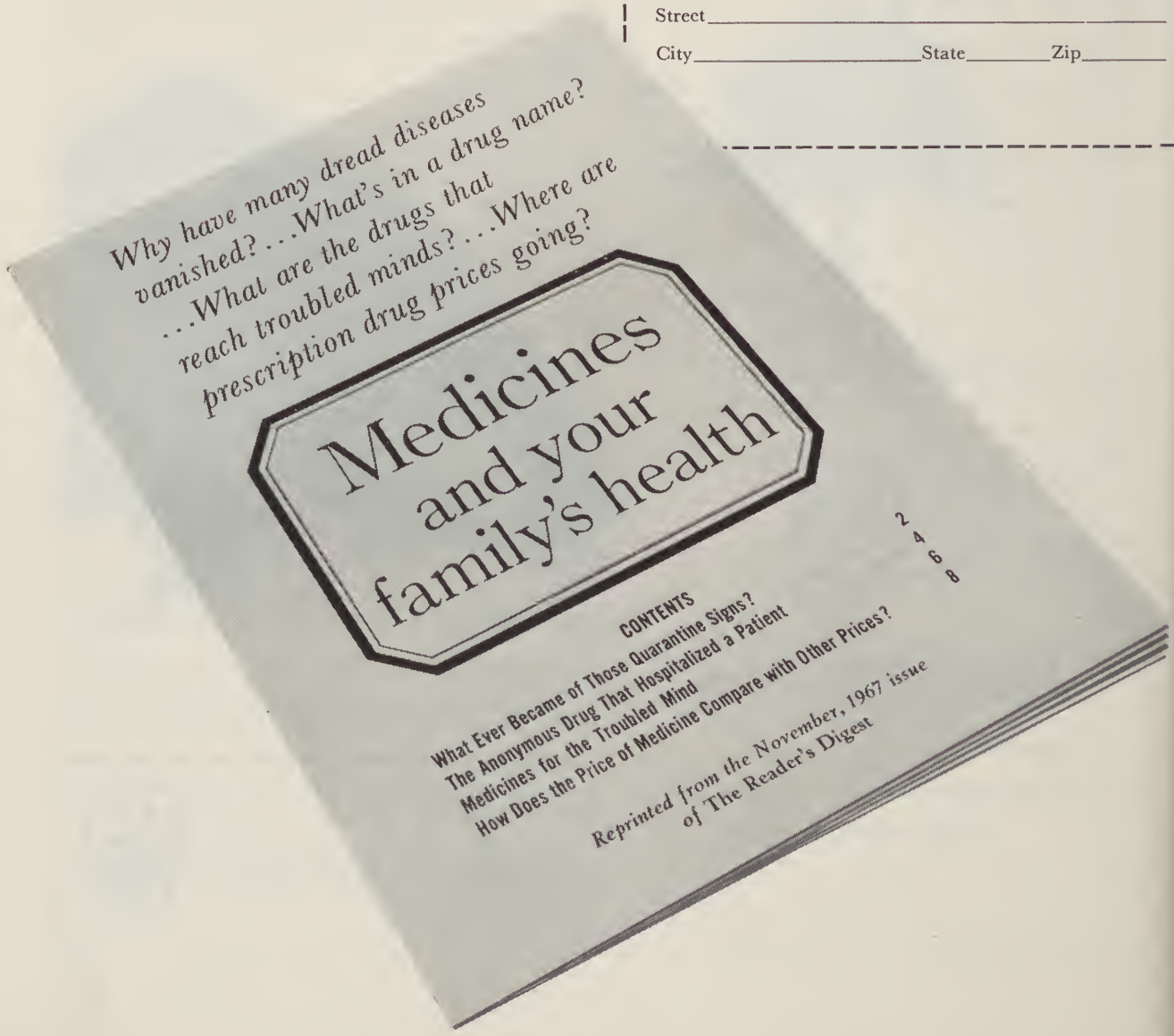
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REHABILITATION Notes

REHABILITATION SECTION
BALTIMORE CITY MEDICAL SOCIETY,

DOUGLAS G. CARROLL M.D.
EDITOR

Cardiac Rehabilitation: Part II

Coronary Care Units

DOUGLAS CARROLL, MD
Chief, Physical Medicine and Rehabilitation
Baltimore City Hospitals

Intern:

Infarct Number Ten has a spleen.
The ECG changes are keen;
Wolfe-Parkinson-White,
A shift to the right,
And Bundle Branch Block in between.

Research Fellow:

He's Case Number Ten for my tract:
"The Use of Reserpine Extract."
I'll soon be successor
To dear old professor,
If I can complete the abstract.

Patient:

They christened me John Henry Shinn,
But here I am Case Number 10.
It might be a cancer;
I've gotten no answer.
There's nobody here who will listen.

The above somewhat cynical doggerel is an attempt to illustrate that each specialist in a Coronary Care Unit (CCU) has his own interest and is limited by the very fact that he is a specialist. He is interested in a disease, a technical method, a laboratory finding, a procedure or an area of knowledge—rather than in patients as people. Like the fable of the blind men describing the elephant they had felt, each specialist observes different parts of the whole picture and no one sees the patient as a person.

* * * * *

Nurse:

Dr. Jones wants more notes on Case Ten;
A check on his pulse rate again
He wants information,
Avoids seeing the patient,
And doesn't know where to begin.

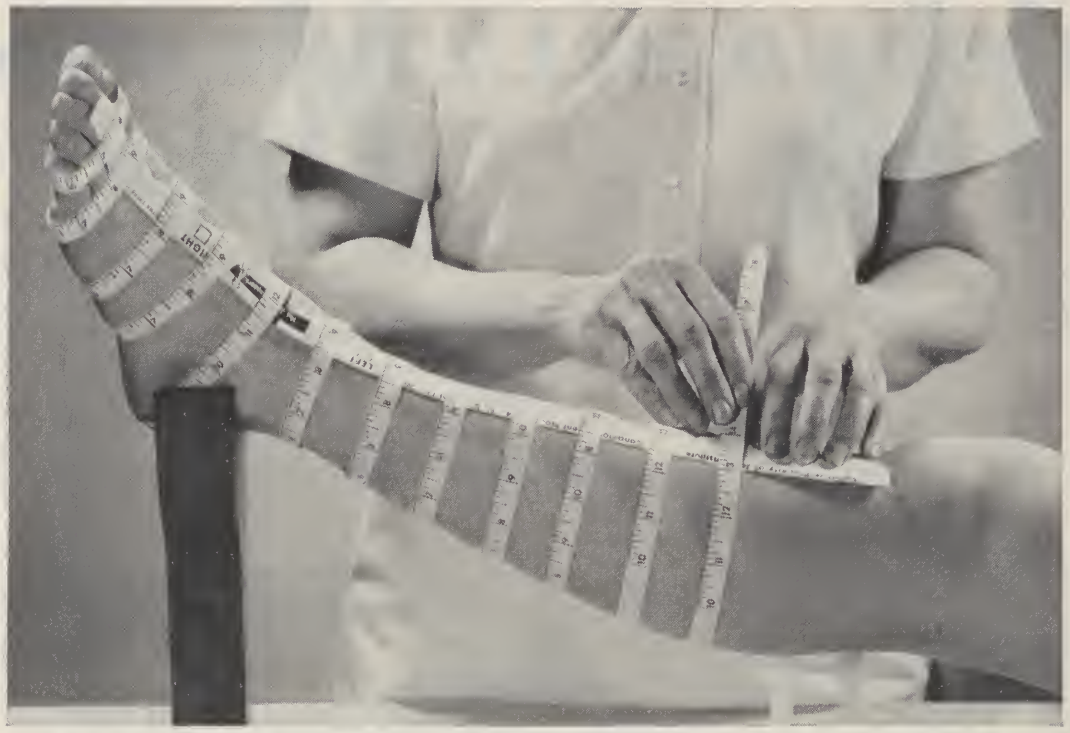
Social Service:

The monitor says he's O.K.,
But he's in a hell of a way
His first wife came in
With two sets of twins
And his second is here with her lawyer.

* * * * *

There is accumulating evidence from many sources[1,2] that the hospital mortality rate from acute myocardial infarction can be reduced by the use of a well-organized and equipped CCU. Early mortality can be reduced and late complications handled more effectively. The establishment of CCU's should be enthusiastically supported throughout the country.

With every advance, however, there are some losses. There is no question that development of progressive patient care (PPC), respiratory units (RU), intensive care units (ICU), recovery rooms (RR) and coronary care units CCU is resulting in better technical medical care, but there is clear evidence that the patient's emotional problems and



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personality are being neglected. Fortunately in the case of CCU, these deficiencies can be eliminated if the problem is clearly recognized and action is taken. The difficulty is not so much recognition of the problem, but doing something about it.

The Problem

Frederick A. Whitehouse, MD, former director of rehabilitation for the American Heart Association, recently stated that heart disease is one of the greatest neurotic ailments of all time. He estimated that twenty million Americans are victims of wholly imaginary cardiac disorders. They limit themselves physically and psychologically, and derange the relations within their family and work because of their fears and anxiety. It is essential that these reactions be prevented in patients who come into CCU with acute myocardial infarctions.

There seem to be three major reasons why the emotional life of the patient in the Coronary Care Unit is not given full consideration. All of these are results of increasing specialization within the medical and para-medical field.

Emphasis on techniques, research and organization rather than on patients as people

Not only the doctor but also the nurse is specialized in the care of patients in CCU's. There is a move afoot to start specialization among medical students in their third and fourth years. The result of this specialization of professional staff is interest in *diseases* rather than people, interest in *research* rather than service.

Another result of the specialized CCU may be the elimination of the patient's personal physician as a significant figure. Because of the highly specialized techniques required, the housestaff or even the nurse may be much better qualified to render emergency treatment than the personal physician. The personal physician feels unneeded and may not be welcomed by either the medical staff or the patient.

Division of responsibility

Because a group of physicians and nurses are involved in the care of the patient, each tends to have his own specialized area of action. No one takes full responsibility for the total care of the patient. The patient's private personal physician will have the responsibility of talking to the patient about the meaning of his heart attack and his future activities at work and in the family. If the patient does not have such a concerned and responsible personal physician, no one may talk to him about the meaning of the disease. This division of responsibility is characteristic of all team or committee type medical care.

Proliferation of technical personnel

The rapid development of new monitors and other machinery for use in ICU's makes the development of new technicians inevitable. There is a plan afoot to develop assistant-doctor-technicians whose duty in a CCU would combine those of a doctor, a nurse and an electronic repairman. He would introduce catheters, operate a defibrillating machine and other techniques which ten years ago were in the laboratory being developed by physicians. Depending on technicians to perform many of the services now performed by the doctor will tend to separate the responsibility for total patient care still further.

The Solution

It is persiflage to say that recognition of this problem will automatically result in improvement in total patient care. Depersonalization has been widely recognized in hospitals[3,4,5] for decades. Indeed the very term "Coronary Care Unit" reveals an unconscious disease-orientation rather than patient-centered concern.

Attempts to solve this problem by social workers, ministers, conferences, teams and committees are bound to fail, because all of these methods attempt to remove the responsibility from the physician, where it rightfully belongs. To paraphrase Francis Peabody.[6] "Unless the physician cares about the patient, the patient's care will be poor".

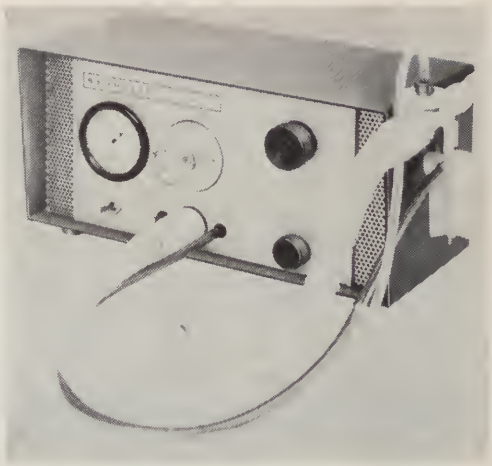
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Department of Mental Hygiene

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The Hospitalized Geriatric Patient

In 1950 there were 12 million Americans aged 65 and older; by 1960 this number had increased to more than 16 million and it is now estimated to have reached 20 million. While the 275,000 Maryland residents in this age group represent 7.5 percent of the state's total population, patients 65 years of age or older currently occupy 29.9 percent of all beds in Maryland's four regional mental hospitals. The distribution of these 2,406 patients by diagnosis and by length of hospitalization is shown in the following table.

These data indicate that geriatric patients can be divided into two broad categories of nearly equal size. The patients who were first hospitalized in old age have been under continuous care for relatively short time periods and were primarily admitted for diseases of the senium. The patients first hospitalized at a younger age have been under continuous care for relatively long time periods and were primarily admitted for psychotic disorders.

In 1966 there were 963 admissions in this age group while 250 patients became 65 while hospitalized. At the same time, it accounted for 437 discharges and 764 deaths. A significant reduction in the number of these older admissions and resident patients is attainable through a coordinated program relating the following areas:

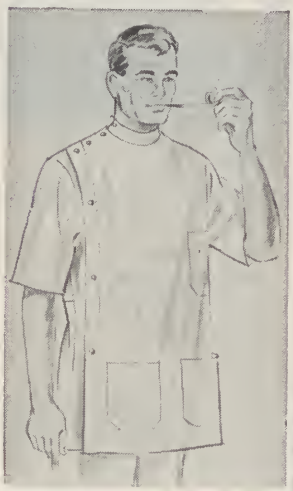
1. Imaginative services in the mental hospital designed to minimize the number of patients who become chronic.
2. Establishment, expansion and improvement of state licensed and inspected nursing homes and other suitable alternatives to hospitalization.
3. Development of services in general hospitals for the concomitant treatment of physical and mental illnesses.
4. Development and expansion of supportive community services and programs, such as meals on wheels and golden age clubs.
5. Providing financial independence and resultant self-esteem through Social Security and Medicare.
6. Elimination of involuntary automatic retirement at specified age levels.

Length of Hospitalization	Total	Diseases of Senium	Other Brain Syndromes	Psychotic Disorders	All Others
Less Than 1 Month	76	45	9	7	15
1–11 Months	380	271	48	36	25
1–4 Years	649	490	78	51	30
5–9 Years	226	111	47	61	7
10 Years or More	1,075	81	135	724	135
TOTAL	2,406	998	317	879	212
Median (Years)	7.2	2.5	7.5	10+	10+

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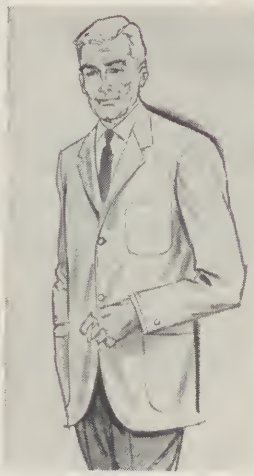
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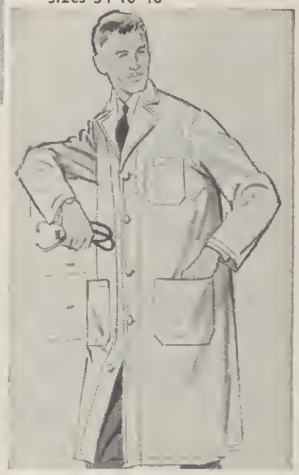
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STATE OF MARYLAND
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Highlights

ASEPTIC MENINGITIS DECLINING

Localized outbreaks of aseptic meningitis, chiefly in Baltimore City, began about July 1 and reached a peak early in September, declining slowly thereafter. The disease was relatively mild, lasting 4 to 7 days, with symptoms of headache, fever, stiff neck and occasionally a rash and gastrointestinal upset. The spinal fluid cell count was elevated, as high as 1600 in one case. In a 16-week period, 117 specimens were examined by the Bureau of Laboratories, and virus isolations obtained from 48 cases. Coxsackie B-5 was isolated from 18 patients, Echo 4 from 17, Echo 9 from 9, and miscellaneous enteroviruses from the remainder. 70% of the patients were under 15 years of age.

VIRUS ACTIVITY IN MARYLAND

During the late summer and early fall of this year, considerable virus activity occurred in Maryland as determined by the isolation of a large number of viruses from clinical materials received by the Bureau of Laboratories. Approximately 700 specimens were examined during this time and viruses were isolated from 21%. Viruses recovered were coxsackie B-4, coxsackie B-5, coxsackie A-9, echovirus type 4, echovirus type 9, adenovirus type 3, adenovirus type 7a, herpes simplex, varicella, cytomegalovirus, poliovirus type 2, and twelve unidentified enteroviruses.

GOVERNOR'S TB COMMITTEE REPORTS

The Governor's Committee to Study Tuberculosis Control in Maryland, appointed in September 1965, recently presented a report of its findings. Among its recommendations, some of which have already been implemented, the committee advises the adoption of firm statewide control policies with expansion and strengthening of the Division of Respiratory Diseases. Funds to accomplish this have been requested in the Department's 1969 budget.

DRUG ABUSE LAW TO BE INTRODUCED

The Department's Division of Drug Control has drafted a "Model State Drug Abuse Act" to enable regulation and control of barbiturates, amphetamines, and other drugs with a potential for abuse because of their depressant, stimulant or hallucinogenic effects. Designed to conform with federal statutes, the act would require accurate records to be kept by all those engaged in the manufacture, delivery or distribution of such drugs, would impose an expiration date of six months on prescriptions, and would limit refills to five, after which a new prescription would be needed to obtain further supplies.

GERMAN HEALTH OFFICIALS VISIT ALLEGANY LANDFILL

Two German health officials, from the Central Office for Solid Waste Disposal of the Institute of Water, Soil and Air, German Ministry of Health, recently visited the Frostburg sanitary landfill in Allegany County, where a three-year demonstration project is under way to determine the feasibility of combining land reclamation of abandoned strip mines with a possible solution to the state's mounting solid waste problem. The project,

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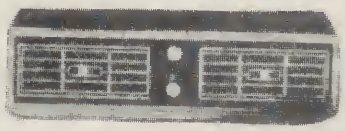
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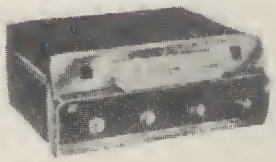
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financed by a US Public Health Service grant and funds from the citizens of Frostburg and Allegany County, was planned and is operated by personnel from the Department's Division of Solid Wastes. Earlier this year, a team of American public health officials, including Maryland's Assistant Commissioner for Environmental Health Services, made a similar trip to Germany. The interchange is part of the two countries' Cooperative Program in Natural Resources, Pollution Control, and Urban Development.

CARE OF STROKE PATIENTS

The problems faced by community hospitals in the care of stroke patients were discussed at a recent all-day symposium co-sponsored by the Heart Association of Maryland and the Health Department. The 150 participants included physicians, nurses, physical and occupational therapists, and hospital administrators, and represented 33 hospitals throughout the state as well as local health departments.

APPEALS HEARD ON MEDICAL ASSISTANCE PROGRAM

In the first year of operation of the Medical Assistance Program, from June 30, 1966 to July 1, 1967, 73 appeals for fair hearings were received by the Health Department. Most of these resulted from Department of Welfare decisions on eligibility, only 18 being based on inability to obtain medical care; nine of these were referred to local health departments, and nine were judged inappropriate for appeal. Since July 1, there has been a steady increase in appeals on eligibility determination, probably related to added eligibility restrictions and to rising costs of medical care, especially in hospitals and nursing homes.

200 ENROLLED IN HOME STUDY COURSE

About 200 state and local personnel are currently enrolled in the 17-lesson homestudy course in Environmental Sanitation developed by the National Communicable Disease Center of the US Public Health Service, and co-sponsored by the State and Baltimore City Health Departments. Designed to teach the general principles of sanitary science, the course is a prerequisite for an 8-week, full-time training course to be offered to all Maryland sanitarians for the first time in February 1968. Successful completion of both courses qualifies persons to be certified by the American Public Health Association as Registered Sanitarians.

NUTRITION TO RECEIVE INTERAGENCY APPROACH

The Chief of the Division of Nutrition and the Food Service Director of the Division of Respiratory Diseases are chairman and vice-chairman, respectively, of the new Maryland Interagency Committee for Improved Nutrition. The new committee was established to promote the coordination of nutrition services throughout the state.

VISION-HEARING SCREENING WORKSHOPS WELL ATTENDED

The training and refresher course in vision and hearing screening techniques, conducted recently in three locations throughout the state, was attended by approximately 150 public health nurses, school nurses, and technicians. The course, given in cooperation with the Department of Education, was under the direction of the School Health Section, Division of Maternal and Child Health, and hearing consultants to the Crippled Children's Division. Audiologists from Johns Hopkins and representatives of the Maryland Society for the Prevention of Blindness participated.

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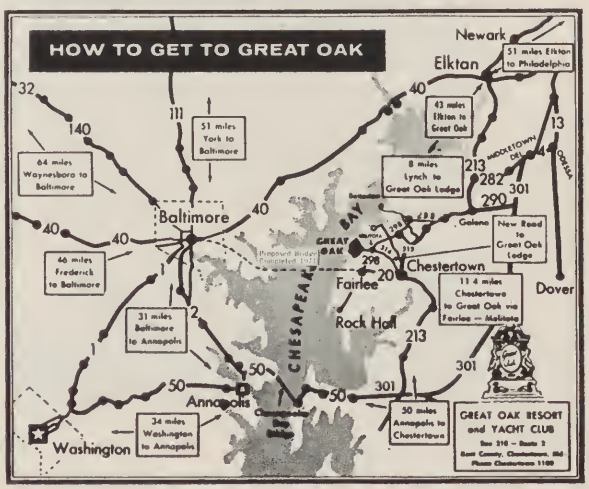
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Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make regular blood counts. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Purpuric rash has also been reported. Agranulocytosis, ex-

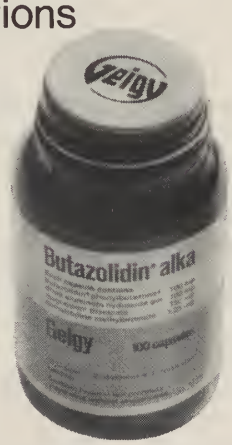
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foliative dermatitis, Stevens-Johnson syndrome, or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

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Alcoholism SECTION

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

Folklore and Facts about Employees with Alcoholism—Part 1

LEWIS F. PRESNALL
New York, N. Y.

As a prelude to this topic, some of the events of the past 22 years, relating to the development of rehabilitation programs for employees having alcoholism should be reviewed.

In 1943, the first effort was established by a major multiplant company in the United States to help employees with alcoholism. A year later the National Council on Alcoholism—the national voluntary health agency in this field—was founded by Mrs. Marcy Mann. Alcoholics Anonymous had been started in 1935 and had already begun to demonstrate conclusively that a large number of alcoholics, generally thought to be hopeless cases, could recover. It had also been demonstrated that employees with alcoholism could frequently recover and be retained as valuable, dependable workers.

During the period from 1944 to 1959, the National Council on Alcoholism and its affiliates in industrial cities worked with most of the companies, unions, and government agencies that attempted, often with considerable success, to establish alcoholism programs for employees. Staff members of the Yale Center of Alcohol Studies also assisted interested companies. Seldon Bacon, MD, and Ralph M. Henderson developed "The Yale Plan for Business and Industry," which was a general outline of suggestions on how to deal with alcoholism among employees.

However, during the 16 years from 1944 through 1959 there was no sharp increase in the number of companies that initiated alcoholism programs each year, in spite of the reported success of those corporations that were already conducting programs resulting in recovery of over 50% of the alcoholic patients receiving treatment.

The National Council on Alcoholism, the Yale Center of Alcohol Studies,* the growing number of official state-supported alcoholism agencies, and private individuals who had recovered from alcoholism, had invested much time and energy in their efforts to interest more employers in the installation of formal programs on alcoholism. By 1959 there were only about 50 companies, large and small, that could be said to have formal programs in full operation—in any way approaching maximum effectiveness.

Much good had been accomplished and through the existing programs, the effective working lives

Mr. Presnall is Director of Industrial Services, National Council on Alcoholism.

Presented at the Ninth Annual Western Industrial Health Conference San Francisco, Calif., Oct. 8, 1965.

* Now the Rutgers Center of Alcohol Studies.

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Diarrhea, one of the most vexing symptoms of common G. I. disorders can often be curbed with Cantil (mepenzolate bromide), bringing welcome relief to the harassed patient. Relatively specific for the hyperactive colon, it helps reduce diarrhea, pain and spasm with minimal effect on other viscera. Cantil (mepenzolate bromide) is indicated whenever these symptoms are associated with irritable colon, gastroenteritis, diverticulitis, and mild to moderate ulcerative colitis.

It is an anticholinergic drug without narcotic properties. Side effects are usually mild.

IN BRIEF: One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth, blurring of vision, constipation, nausea, vomiting, bloating and dizziness may occur but are usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy — withhold in glaucoma. Contraindicated in patients sensitive to phenobarbital and/or Cantil (mepenzolate bromide); in toxic megacolon, obstruction of G. I. or G. U. tract.

SUPPLIED: CANTIL (mepenzolate bromide) — 25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL — containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

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of many employees had been extended, but the rate at which these pioneer efforts of industrial health and industrial relations were adopted by other companies was discouraging.

A Search for New Approaches

Late in 1960 it was decided by the National Council on Alcoholism (*NCA*) that it was time to develop some new approaches to the problem. Since 1944, a vast amount of information had been accumulated about what did and did not work in the alcoholism programs of various companies. Data were available to *NCA* on all successful programs. Even more importantly, much data had been accumulated regarding approaches that had failed. In any pioneer field, one learns most from the failures but, unfortunately, no one published his failures. However, *NCA* was in the unique position of having such information since the organization had been in close touch with company programs that had been started and later encountered such serious difficulties that they were dropped and forgotten.

With these resources as a starting point, *NCA* was fortunate in having the advice and counsel of Mr. Clifford F. Hood, former president of U. S. Steel Corporation and presently a member of its executive committee and board of directors. He formed a small industrial advisory committee of other leading corporation officials. This group then began working closely with *NCA* staff to develop services designed to provide information and assistance to companies, unions, and government employers regarding alcoholism programs. A staff member with industrial experience was assigned to work with the committee. In developing a specific department of industrial services at *NCA* there were 4 basic unanswered questions which were revealed by an evaluation of the older alcoholism programs: 1. In the face of a growing mass of evidence, why were companies so reluctant to accept alcoholism as a serious problem among employees? 2. Why had so many so-called successful alcoholism programs been unable to reach salaried and executive personnel with early help when they developed alcoholism? 3. What were the reasons for the high mortality rate of alcoholism programs? (Perhaps 5–10 programs had been started for each program that survived as a permanent part of policy and procedure.) 4. How could better methods be developed for early identification of alcoholism and motivation of alcoholics to seek help?

Through analysis of past experience some solid answers to these questions began to appear.

In a sense it was necessary to formulate what amounted to the methodology of a new profession. This was done by combining the methods used in the field of community organization, with its most sophisticated technics of fact-gathering, and the methods of management consultation. The approaches resulting from the merging of these 2 methodologies were tested in the field and evoked responses from companies which indicated that employers did want, and could use this kind of consultation.

A final problem then had to be solved. Where could staff people be found who were capable of implementing this new professional method? People were not available who had the precise experience or training to apply the new approach. Thus, the *NCA* began to recruit a staff of individuals who had either extensive industrial-line and staff experience or who had worked in industrial consultation: people who had both the aptitudes and the background to integrate the new methods with their previously acquired skills. Following recruitment, *NCA* put the new staff people through an intensive work-in-training orientation.

These new approaches are apparently meeting the practical needs of employers. The number of companies developing new alcoholism programs increased 357% from 1959 to 1965.

Folklore and Alcoholism

All employers face broad problems regarding alcoholism among employees, but there are certain practical technics that can be applied in the field of occupational health.

In an age that has produced the computer, consumer research, and new systems of cost control, there are many new areas where action of the business community can be based upon objective facts and rational thought. Nevertheless, every alert leader of government, labor, and industry knows that there are many areas of personnel practice where folklore, not fact, continues to dominate many of our discussions; one of the most important to the productivity and longevity of employees is alcoholism.

IRON DEFICIENCY

ANEMIA



Imferon®
(iron dextran injection)

There's as much iron . . . 250 mg. . . . in a 5 cc. ampul of Imferon (iron dextran injection) as in a pint of whole blood. When iron deficient patients are intolerant of oral iron . . . or orally administered iron proves ineffective or impractical . . . or if the patient cannot be relied upon to take oral iron as prescribed, Imferon (iron dextran injection) dependably increases hemoglobin and rapidly replenishes iron reserves. Precise dosage is easily calculated.

LAKESIDE

IN BRIEF: ACTION AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion as a source of iron; infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

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Folklore can represent the accumulated practical wisdom of a people. Our deep-rooted beliefs about democratic processes is an example. The folklore about democratic methods is based upon hard-won, practical experience. It works because it is folklore built upon facts. In contrast, the prevalent folklore about alcoholism is the product of ignorance, prejudice, half-truths, frustration, and the heritage of the "wet-dry" controversy in this country. In order to cope intelligently and effectively with alcoholism, we must make an attempt to free ourselves of the effects of this folklore with which our minds have been inundated since childhood.

Erroneous folklore about alcoholism affects our actions regarding employees. In suggesting more constructive approaches, I will be drawing, not only from my own professional work in this field, but more importantly, from the 20 years of experience which the *NCA* has had in working with most of the companies, unions, and government groups that have attempted to develop alcoholism programs. Knowledge gained from this experience has now become extensive. Naturally, it includes both stories of success and lessons of failure. Only a small fraction of that information can be discussed in the time allotted to us. Therefore, I have arbitrarily selected 4 crucial areas in which folklore misdirects our action on the industrial scene: 1: identification of the scope of the problem, 2: company policy, 3: the role of labor unions, and 4: procedures that supervisors might use.

(To be continued in January 1968)

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Recently Modell[2] has stated: "The mercurial diuretics are the injectable diuretics of choice since they are the most potent as well as the most dependable. Their toxicity is not an important consideration either by comparison with other potent diuretics or in relation to the seriousness of the conditions in which they provide such excellent relief."

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IN BRIEF

Mercuhydrin is indicated in edema of cardiac or hepatic origin and in the nephrotic syndrome; it is contraindicated in acute nephritis and in anuric or oliguric states. *The usual adult dose is one to two cc. daily or every other day until "dry weight" is obtained.* Sensitivity is rare but small initial doses are advised to minimize potential reactions; vertigo, fever, and rash have occurred. Overdosage may produce electrolyte depletion, muscle cramps, and G.I. reactions. Supplied: 1 cc. and 2 cc. ampuls in boxes of 12, 25 and 100; 10 cc. rubber capped, multiple-dose vials (intramuscular or subcutaneous use only) in boxes of 6 and 100.

1. Gold, Harry, *et al.: A System for the Routine Treatment of the Failing Heart,* The American Journal of Medicine, Vol. III, No. 6:665-692 (Dec.) 1956.

2. Modell, Walter: *Drugs of Choice 1966-1967,* p. 97, 1966.

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Woman's Auxiliary
MARYLAND
HYGEIA FILIAE
W A M C F

DECEMBER, 1967 MRS. HARRY L. BERMAN, Editor

INTERNATIONAL NUCLEAR MEDICINE MEETING IN LONDON

The Imperial College of London was the site recently for the International Nuclear Medicine Symposium, arranged by the Institute of Cancer Research, Royal Cancer Hospital, England.

Approximately 300 physicians with a specific interest in this field, along with various scientists and equipment manufacturers who have related interests, met to discuss the common problems involving the use of radioisotopes in the localization of tumors.

Many came with their wives to combine pleasure and work, to visit and revisit treasure-filled museums, sights of historic interests, and/or shop at hard-to-find tucked-away places. Guided tours were conducted to Hampton Court Palace, built in 1514 by Cardinal Wolsey and "presented" to Henry VIII, to the Houses of Parliament, and to the Tower of London. Following the tour a uniquely presented evening feature on the history of the "Tower" was given in the form of a play. Last, but surely not the least for the ladies, was the inevitable fashion show presented by Harrod's of London.

The purpose of the meeting was to enable physicians to make earlier diagnoses of cancer, and show whether or not these cancers have spread beyond their original sites. To cover this rapidly expanding field would require far more space than is available here.

However, strong emphasis continues to be placed on research in the early detection of cancer, and devices of various kinds for the detection of tumors in different sites of the body formed the principle basis for discussion. Since these intruments involved a display of images with distinctive patterns facilitating diagnosis of tumors the technical details involved in the production of such images consumed a large part of the presentation.

This was the first international meeting of its kind in the field of Nuclear Medicine. As one might anticipate, some of the work shown is still in the developmental stages and not ready for the practicing physician.

The over-all management of the Symposium, its technical and scientific exhibits, the opportunities for sight-seeing in London and the programs for the ladies were all managed commendably. Those who attended are looking forward to the next, yet unannounced, meeting of this group.

Ellen Jean Berman

ANNUAL MEETING

Woman's Auxiliary to Med-Chi

THURSDAY, APRIL 18, 1968

Headquarters: Sheraton Belvedere Hotel, Baltimore

SPECIAL FEATURE—Wednesday evening, April 17, 1968, *AMA-ERF BENEFIT*—under the auspices of the Auxiliary. A night at the Morris Mechanic Theater, Baltimore, "You Know I Can't Hear You When The Water's Running" starring Eddie Bracken

For Information: Mrs. H. Melvin Radman, Chairman, AMA-ERF Committee, Esplanade Apartments, Baltimore, Md. 21217. Tel: LA 3-4410

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IN BRIEF:

INDICATIONS: In depression of any kind —neurotic and psychotic depressive reactions; manic-depressive or involutional psychotic reactions.

CONTRAINDICATIONS: Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease, epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor.

RELATIVE CONTRAINDICATIONS: (1) Patients with a history of paroxysmal tachycardia. (2) Patients receiving concomitant therapy with thyroid, anticholinergics or sympathomimetics may experience potentiation of effects of these drugs. (3) Safety in pregnancy has not been established.

PRECAUTIONS: (1) Outpatient use of desipramine hydrochloride should not be substituted for hospitalization when risk of suicide or homicide is considered grave. (2) If serious adverse effects occur, reduce dosage or alter treatment. (3) In patients with manic-depressive illness a hypomanic state may be induced. (4) Discontinue drug as soon as possible prior to elective surgery.

ADVERSE EFFECTS: Side effects, usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, anxiety, agitation and stimulation, insomnia, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, tremor, allergy, agranulocytosis, altered liver function, ataxia, and extrapyramidal signs.

DOSAGE: Optimal results are obtained at a dosage of 50 mg., t.i.d. (150 mg./day). **SUPPLIED:** NORPRAMIN (desipramine hydrochloride) tablets of 25 mg.; bottles of 50, 500 and 1000; and tablets of 50 mg., in bottles of 30, 250 and 1000.

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COMPONENT MEDICAL SOCIETIES

BALTIMORE CITY

The meeting of the Board of Directors was called to order by Harry J. Connolly, MD, on Tuesday, October 10, 1967 at 4:30 P.M. at 1211 Cathedral Street, Baltimore, Md. Ten of the members were present at this meeting. The minutes for the September 5th meeting were read and unanimously approved. The first item on the agenda was membership review, in which two members of the Society requested transfer of their active membership to associate status. A waiver of dues was granted for a member of the Society because of prolonged illness. D. Frank Kaltreider, MD, brought the board up to date on the matter of the abortion bill and reviewed many of the details associated with such a bill. He reviewed the two bills proposed by Dr. James Prescott, a member of the Maryland Psychological Association. It would appear that one of Dr. Prescott's bills is very similar to that of the American Medical Association, while the second bill presents a new thought and approach to the problem by putting the matter in the hands of the medical profession rather than with the Legislature. An enthusiastic discussion by the board followed the presentation of this subject. A vote was taken by the board members as Dr. Kaltreider wished to report the unofficial opinion of the board of directors to I. M. Cushner, MD, before the October 18th meeting of the Legislative Council of the Senate and House. Six members of the board approved in principal the Prescott Bill and three voted in favor of the *AMA* bill. The subject of classified telephone directory listings was reviewed by the board. The following motion was made, seconded and passed:

["We are in favor of the mediation committee's recommendation regarding listings and that the Baltimore City Medical Society inform its membership at the November 3rd meeting of this action."] Several physician-patient complaints were considered in detail by the board and recommendations were appropriately made. The meeting was adjourned at 5:50 P.M.

Arthur E. Cocco, MD
Journal Representative
From the Baltimore City Medical Society

MONTGOMERY COUNTY

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Wednesday January 17, 1968
Cocktails 11:30 AM; Luncheon 12:30 PM
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Music by Devron; Master of Ceremonies—Al Ross, WRC
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The proceeds will benefit American Medical Association Educational Research Foundation and Montgomery County Workshop for the Handicapped.

Mrs. John B. Umhau, Jr. is President of the Auxiliary and Mrs. Ira Tublin and Mrs. Albert Zelna are Co-Chairman of the Benefit.

For tickets call or write, Mrs. Richard Lukes, 9906 Old Spring Road, Kensington, Maryland, 20795, telephone WH 2-1540; or Mrs. Albert Grollman, 11300 Rolling House Road, Rockville, Maryland, 20852, telephone 881-4461.

We'll look forward to seeing you on January 17th for a day full of fun and excitement that will help other people.

NEW PRESIDENT FOR MONTGOMERY COUNTY MEDICAL SOCIETY

Marvin I. Mones, MD, a leading Silver Spring pediatrician, will assume the presidency of the Montgomery County Medical Society the first of December 1967. The office of president will not be the first elective office for Dr. Mones, as he was the President of the Board of Holy Cross Hospital in 1965 and has held various other offices in the Society. In addition to his local memberships, Dr. Mones is also a member of the American Academy of Pediatrics, the American Board of Pediatrics, and the American Medical Association.

A native of Philadelphia, Pa., Dr. Mones received his B.S. from Villanova College in 1940, saw service in the Army during World War II and graduated from Johns Hopkins Medical School in 1947. After completing his residency there, he entered private practice in Silver Spring in 1950, where he is still engaged in the practice of pediatrics. A busy doctor he is, nonetheless, an instructor at Georgetown University School of Medicine and Attending Pediatrician at Children's Hospital, as well as a member of the Board of the Nursery School for Brain Damaged Children.



MARVIN I. MONES, MD

PRESENTATION TO OUT GOING PRESIDENT OF MONTGOMERY COUNTY MEDICAL SOCIETY

Late Friday evening, November 17, at the Woodmont Country Club during the Annual Dinner Dance of the Montgomery County Medical Society, where more than 150 physicians and their wives were present, John O. Robben, MD, a Montgomery County surgeon was presented with a specially designed hammered copper plaque in recognition of his outstanding leadership of the medical community during 1967. This will be the last time that Dr. Robben will officially preside and will present the symbol of chairmanship—*the walnut gavel*—to Marvin I. Mones, MD, a Silver Spring pediatrician, the 1968 president of the Society.

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ROYAL SOCIETY OF MEDICINE

Schedule of Special Meetings

Tuesday, February 6, 4:30 p.m.
Orthopedics, clinical session followed by general discussion

Wednesday, February 7, 5:15 p.m.
History of Medicine*

February 7, 8 p.m.
Surgical Section

Thursday, February 8, 5 p.m.
Ophthalmological, Endocrinology combined Session

February 8, 8 p.m.
Occupational Medicine

Friday, February 9, 4 p.m.
Special Interests Clinical Section

*Lord Cohen of Birkenhead reception

MARYLAND ASSOCIATION OF MEDICAL ASSISTANTS

DECEMBER, 1967

MEDICAL-LAW COURSE FOR BALTIMORE ASSOCIATION

The Baltimore Association of Medical Assistants offered a course in medical-law, from September 14, 1967, through November 9, 1967. Raymond V. Rangle MD, conducted the classes held at the Baltimore Junior College for eight weeks.

Members of the Baltimore Association of Medical Assistants and guests attended the meetings at the college. The course proved to be a valuable aid to the members of the association who intend to take the certification examination in June, 1968.

Dr. Rangle is an internist and director of a clinical laboratory in Baltimore city. He received his BS degree from the University of Maryland, and his MD degree from the University of Maryland School of Medicine. Following his internship at University Hospital, he was Assistant Resident Pathologist at Baltimore City Hospitals. He was Assistant Pathologist at Maryland General Hospital, and Chief Pathologist at North Charles Street General Hospital. In 1965, Dr. Rangle received his LLB degree from Mount Vernon School of Law.

Dr. Rangle has been most active in many civic organizations, and in 1967 was selected as Outstanding Community Leader by the Outstanding Civic Leaders of America. In 1963 he was chairman of the Equal Opportunity Commission of Baltimore City, and he is presently on the advisory board of the Salvation Army Day Nursery. In 1958, Dr. Rangle received the Salvation Army Certificate Award for charitable medical services rendered from 1944 until the present.



R. V. RANGLE, MD
Instructor for Medical B.A.M.A.
Medical Law Course.

GORDON GRAU, MD SPEAKS TO MEDICAL ASSISTANTS

E. Gordon Grau, MD, was the guest speaker at the October meeting of the Baltimore Association of Medical Assistants. Dr. Grau spoke on the *Psychiatric Treatment of Sexual Deviations.*

Dr. Grau's presentation was most interesting

and enlightening to the audience, for he explained the psychological problems and motivations of people with sexual deviations. During his talk, he elaborated on the unhappy lives of homosexuals, and the uncharitable manner in which many homosexuals are treated. Unfortunately in psychiatric treatment of homosexuals, sometimes the patient is not cured; however, as with any other disease, the patient is aided in living with his problem. Dr. Grau explained the various psychiatric techniques employed in dealing with sexual deviations, and emphasized the responsibility of the medical assistant to act in a professional and kind manner when encountering patients with this particular illness.

Dr. Grau was graduated from Loyola College with a BS degree in 1944. He received his MD degree from the University of Maryland, School of Medicine. He did his internship at St. Joseph's Hospital and his residency at Lutheran Hospital. Dr. Grau was in private practice in medicine until 1964, when he joined the staff of The Sheppard and Enoch Pratt Hospital as a resident in Psychiatry. He is president of The Baltimore County Medical Association.

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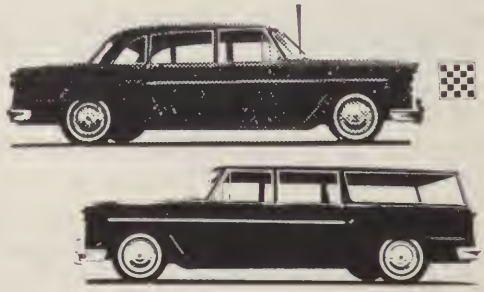
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MEDIC PROGRAM FOR JANUARY—FEBRUARY

JANUARY 19—12:30 P.M.

Treatment of Acute Eye Injuries

Ralph E. Longway, MD, Chief of Ophthalmology, Washington Sanitarium and Hospital

Sponsor: Eugene Leland Memorial Hospital

JANUARY 26—1:00 P.M.

Neurosurgical Aspects of Strokes

Perry Black, MD, Instructor of Neurosurgery, The Johns Hopkins University School of Medicine

Sponsor: Frederick Memorial Hospital

FEBRUARY 2—12:30 P.M.

Burn Unit—Concepts of Burn Therapy

Thomas J. Krizek, MD, Chief, Division of Plastic Surgery, Baltimore City Hospitals

Sponsor: Baltimore City Hospitals

FEBRUARY 9—12:30 P.M.

Diagnostic Problems
Panel Discussion

Moderator: Thaddeus E. Prout, MD, Chief of Medicine, Greater Baltimore Medical Center

Sponsor: Greater Baltimore Medical Center

FEBRUARY 16—12:30 P.M.

The Use of the Umbilical Vein in Diagnosis and Research of Problems of Portal Hypertension

John H. E. Bayley, MD, Chief of Surgery, Prince George's General Hospital

Sponsor: Prince George's General Hospital

FEBRUARY 23—1:00 P.M.

Pulmonary Embolism

Gottlieb C. Friesinger, MD, Assistant Professor of Medicine, The Johns Hopkins University School of Medicine

Sponsor: Frederick Memorial Hospital

Participating hospitals:
Anne Arundel General, Annapolis
Baltimore City, Baltimore
Baltimore County General, Randallstown
Calvert County, Prince Frederick
Cambridge-Maryland, Cambridge
Carroll County General, Westminster
Church Home, Baltimore
Cumberland Memorial, Cumberland
Easton Memorial, Easton
Eugene Leland Memorial, Riverdale
Frederick Memorial, Frederick
Greater Baltimore Medical Center, Towson
Harford Memorial, Havre de Grace
The Johns Hopkins, Baltimore
Kent & Queen Anne's, Chestertown
Lutheran, Baltimore
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North Charles General, Baltimore
Peninsula General, Salisbury
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Prince George's General, Cheverly
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1211 Cathedral Street, Baltimore, Maryland 21201
539-0872
or
Department of Continuing Medical Education
State Department of Health, 301 W. Preston Street
Baltimore, Maryland 21201 837,9000 Ext. 8722

Additional programs published monthly in
Maryland State Medical Journal

Baltimore City Medical Society

1211 Cathedral Street, Baltimore, Maryland 21201

Friday, January 5, 1968, 8:30 p.m.

PRACTICAL ASPECTS OF TRANSIENT CEREBRAL ISCHEMIA

Participants

1. Basic mechanisms of transient ischemic attacks. Albert Heck, MD, Assistant Professor of Neurology, University of Maryland School of Medicine.
2. Evaluation and medical management of transient ischemic attacks.
   Erland Nelson, MD, Professor and Head of the Department of Neurology, University of Maryland School of Medicine.
3. Surgical management of transient ischemic attacks.
   Neal I. Aronson, MD, Assistant Professor of Neurological Surgery, The Johns Hopkins University School of Medicine.

* * *

Question and Answer Period

* * *

MARYLAND PSYCHIATRIC SOCIETY

Francis McLaughlin, MD, *President*
Eugene Brody, MD, *Secretary*
Thursday, January 11, 1968, 8:30 p.m.
Baltimore Hebrew College

JOINT MEETING WITH MARYLAND PSYCHOLOGICAL ASSOCIATION

The Alienated Adolescent—A Challenge to the Mental Health Professions. MILTON F. SHORE, Ph.D., NIMH

Thursday, January 25, 1968

Annual Dinner—Sheraton Belvedere Hotel

MARYLAND OPHTHALMOLOGICAL SOCIETY

William E. Newby, MD, *President*
Irvin P. Pollack, MD, *Secretary*
Thursday, January 18, 1968

JOINT MEETING WITH THE MARYLAND ACADEMY OF OPHTHALMOLOGY

Cocktails 6:30 p.m., Dinner 7:30 p.m.,
Program 8:30 p.m.

Kennedy Warren Hotel, Washington, D. C.

Problems of Ophthalmic Plastic Surgery. ALSTON CALLAHAN, MD, Birmingham, Alabama.

PATHOLOGY SECTION

Edward L. Sherrer, MD, *Chairman*
William J. Hicken, MD, *Secretary*
Monday, January 22, 1968, 8:00 p.m.

Program to be announced.

ANESTHESIA STUDY COMMITTEE

Joint Anesthesia Study Committee of the Baltimore City Medical Society and the Baltimore City Health Department.

Tuesday, January 23, 1968, 7:30 p.m.

Medicine 1968—WMAR-TV (Channel 2)

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BALTIMORE CITY MEDICAL SOCIETY

Committee on Public Medical Education
William Schuman, MD, *Chairman*

Sunday, January 28, 1968, 2:00 p.m.

Renal Dialysis

Arranged by Anthony F. Lewandowski, MD

Sunday, February 4, 1968, 2:00 p.m.

Therapeutic Abortion

Arranged by Israel Zeligman, MD

Sunday, February 11, 1968, 2:00 p.m.

The Pill

Arranged by Israel Zeligman, MD

Sunday, February 18, 1968, 2:00 p.m.

Blood Bank

Arranged by William E. Peterson, MD

Sunday, February 25, 1968, 2:00 p.m.

Anti-Cigarette Program

Arranged by Elliott Michelson, MD

All meetings held at 1211 Cathedral Street unless otherwise stated.

MEDIC

FRIDAY POSTGRADUATE PROGRAMS

January 5, 1968, 12:30 p.m.

MANAGEMENT OF EPILEPTICS—Jerome K. Merlis, MD, Professor of Neurology and Clinical Neurophysiology, University of Maryland School of Medicine.

January 12, 1968, 12:30 p.m.

CURRENT PROBLEMS IN THE PREVENTION OF RHEUMATIC FEVER—Milton Markowitz, MD, Associate Professor of Pediatrics, The Johns Hopkins University School of Medicine.

January 19, 1968, 12:30 p.m.

TREATMENT OF ACUTE EYE INJURIES—Ralph E. Longway, MD, Chief of Ophthalmology, Washington Sanitarium and Hospital.

January 26, 1968, 1:00 p.m.

NEUROSURGICAL ASPECTS OF STROKES—Perry Black, MD, Instructor of Neurosurgery, The Johns Hopkins University School of Medicine.

See the Maryland State Medical Journal for complete list of MEDIC locations.

COMING MEETINGS

February 1968

BALTIMORE CITY MEDICAL SOCIETY

Friday, February 2, 1968

The Adolescent. Discussants will be: KURT GLASER, MD, MATTHEW DEBUSKEY, MD, HERBERT YOUSEM, MD

MARYLAND PSYCHIATRIC SOCIETY

Thursday, February 8, 1968

COMBINED MEETING WITH BALTMORE PSYCHOANALYTIC SOCIETY

MARYLAND RADIOLOGICAL SOCIETY

Tuesday, February 20, 1968, 7:00 p.m.

New Auditorium of The Johns Hopkins Hospital
Dinner at 8:00 p.m., Sheraton-Baltimore Inn

The Radiologic Approach to Diagnosis of Arthritis. JACK EIDEKEN, MD Department of Radiology, Jefferson Medical College Hospital, Philadelphia, Pennsylvania.

SECTION OF REHABILITATION

Wednesday, February 21, 1968, 8:00 p.m.

Available Services and Facilities for Treatment of the Chronically Ill Patient after Evaluation." EDYTHE SCHOENRICH, MD, Chief, Bureau of Chronic Diseases, Maryland State Department of Health.

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A. Code Standards

1. As used in this Code:

(a) The term "drug product" means any pharmaceutical or biological product intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in humans, or to affect the structure or any function of the human body, which is promoted and advertised to the medical profession rather than directly to the lay public.

(b) The term "promotional communications" means (1) journal advertising, mailing pieces, and similar written materials (including, to the extent reasonably practicable, films, exhibits and similar visual presentations) directed to members of the medical profession by the pharmaceutical industry for the purpose of promoting a drug product and (2) written instructions and materials prepared for sales or professional representatives containing representations to be made by them to members of the medical profession. Where compliance with the requirements of this Code is not reasonably practicable within the format of a film, exhibit or similar visual presentation, written materials meeting those requirements shall be distributed to all members of the medical profession attending the presentation.

(c) The term "medical profession" includes allied professions in the health field.

2. Complete and accurate information concerning marketed drug products should be made available promptly to the medical profession. Promotional communications to the medical profession which include a description of indicated uses or dosage recommendations for a prescription drug product should also include a summary (or full disclosure where required by law) of side effects, precautions, warnings and contraindications, and of effectiveness for the described indicated uses. Such summary should have sufficient prominence in terms of type size, location and similar factors to provide reasonable assurance that it will be observed.

3. Statements in promotional communications should be based upon substantial scientific evidence or other responsible medical opinion. Claims should not be stronger than such evidence warrants. Every effort should be made to avoid ambiguity. Whenever statistical or background information or references to unpublished literature or observations are used in promotional communications, the source material should be available to the medical profession upon request.

4. Statements with respect to or quotations from medical literature or from the personal communications of clinical investigators in promotional communications should not distort the intended meaning of the author or the significance of the study.

5. Any comparison with other drug products should be made upon a valid scientific basis.

6. No public communication by a manufacturer shall be made with the intent of promoting a drug product as safe and effective for any use before the required approval of the drug product for marketing for such use is obtained. However, this provision is not intended to abridge the right of the scientific community and the public to be fully informed concerning scientific and medical progress. Thus it is not intended to restrict a full and proper exchange of scientific information concerning a drug product, including appropriate dissemination of investigational findings in scien-

tific or lay communications media, nor to restrict public disclosure to stockholders and others concerning any drug product as may be required or desirable under law, rule or regulation.

7. Promotional communications should have medical clearance before their release.

B. Code Administration

It is the unqualified intent of the Association that each member shall follow strictly the principles set forth in the Code. To that end the members of the PMA are encouraged to submit information to the President with respect to any alleged breach of this Code by any other member. On the basis of such information and any other information available to him, the President shall take appropriate action including, if required, referral of the information to an ad hoc committee of the Board. The committee shall be chosen by the Chairman of the Board unless the member company represented by the Chairman has submitted such information or is the subject of such information, in which case the President shall make the appointments. The General Counsel of the Association shall act as secretary of each ad hoc committee and shall report the committee's findings to the President who in turn will refer the findings to the Board of Directors.

Any member firm which clearly and persistently violates the Code may be asked by the Board of Directors to resign from the Association.

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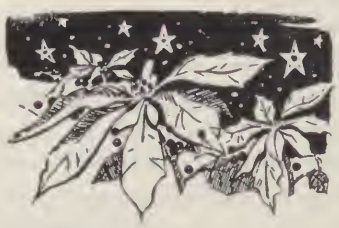
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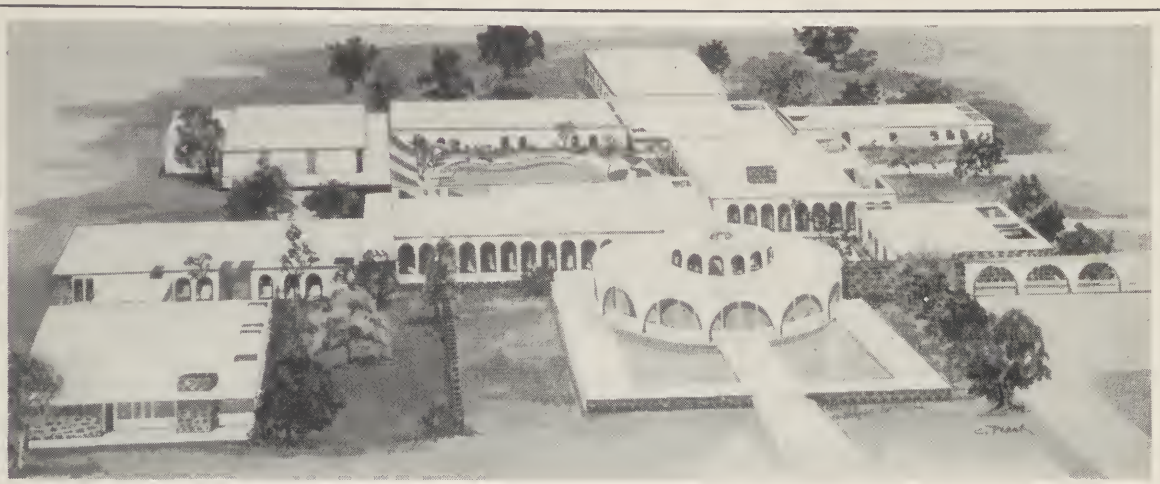
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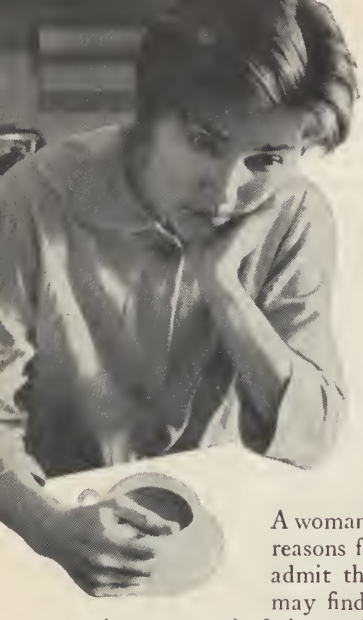
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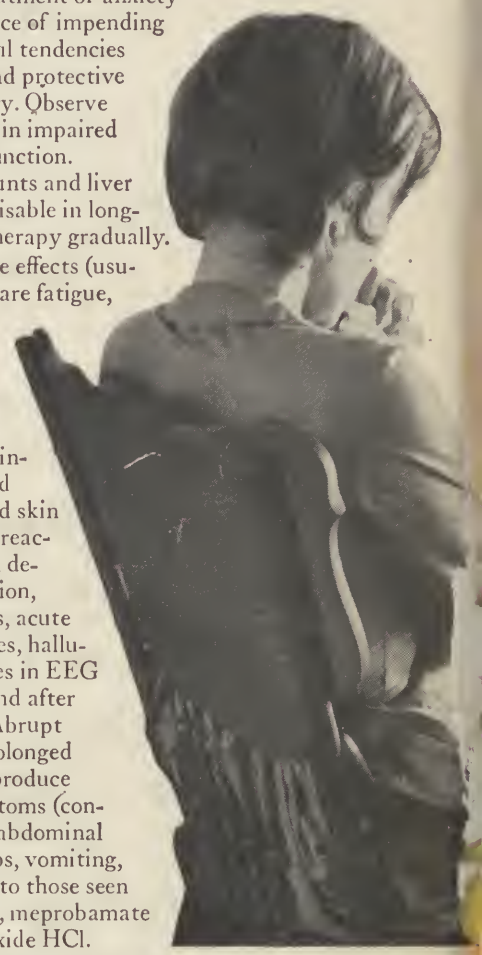


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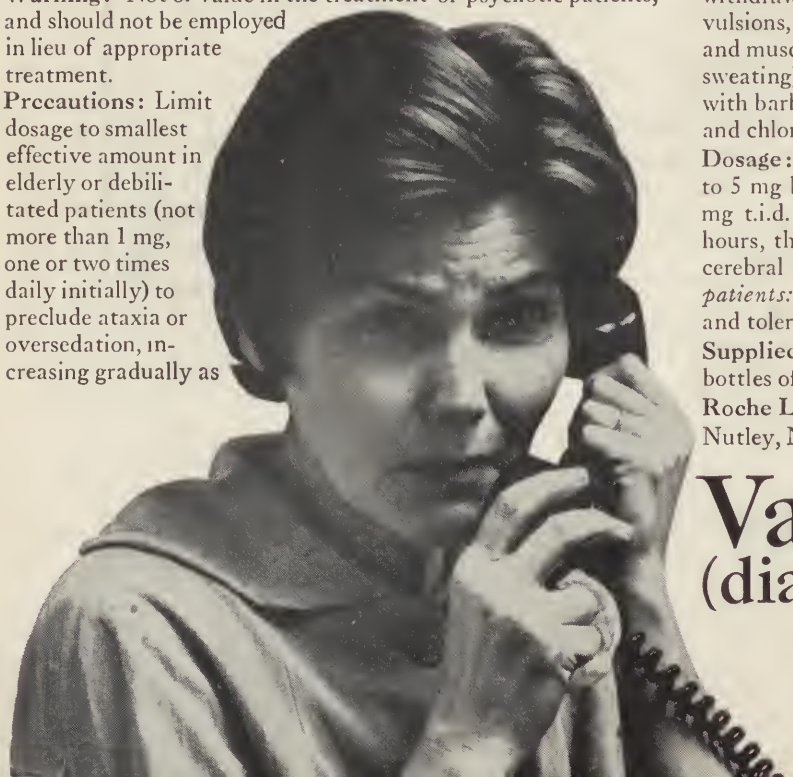


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January-December, 1967

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